SOCIAL SECURITY ADMINISTRATION

OCCUPATIONAL INFORMATION DEVELOPMENT

ADVISORY PANEL QUARTERLY MEETING

JUNE 10, 2009

HYATT REGENCY - McCORMICK PLACE

CHICAGO, ILLINOIS

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C O N T E N T S

ITEM:

C O N T E N T S (CON'T)

P R O C E E D I N G S

MS. TIDWELL-PETERS: My name is Debra Tidwell-Peters. I'm the Designated Federal Officer for the Occupational Information Development Advisory Panel. And we will welcome you to the third quarterly meeting. I'm going to turn the meeting over to the interim chair, Dr. Mary Barros-Bailey. Mary.

DR. BARROS-BAILEY: Good morning, everybody. I would like to welcome you all. This is our third meeting since February, and we are on track now. We are at our third quarterly meeting in two quarters. So welcome, everybody. It's hard to believe that we have only been at this for three and a half months, because there is a lot of work that's been done. I want to, as we launch this meeting, thank everybody for all your hard work.

I would also like to welcome Paul Krieglig (phonetic), the Community Management Officer for Social Security Administration who is sitting in the back. And this Panel meeting we also would like to welcome Associate Commissioner of Office Program

Development and Research, Richard Balkus. Richard is going to be swearing in Dr. Gunnar Andersson to the Panel this morning. So welcome.

MR. BALKUS: Good morning. At the inaugural meeting the Commissioner swore in panel members. Before the meeting ended I had the privilege of swearing in Dr. Barros-Bailey, our interim chair to the Advisory Panel. This morning I have the honor to swear in Dr. Gunnar Andersson as our 12th member of the Advisory Panel.

So Dr. Andersson, I would ask you to raise your right hand and repeat after me.

(Whereupon, Dr. Gunnar Andersson was sworn in.)

MR. BALKUS: Congratulations. Thank you.

DR. BARROS-BAILEY: Thank you, Richard.

Dr. Andersson, Gunnar, welcome, and we're delighted to have you with us today. Would you just take a few minutes and tell us about your background and work. And just -- the mikes just need a slight tap.

DR. ANDERSSON: I am an orthopedic

surgeon. I was trained in Sweden. I practice at Rush University Medical Center here in Chicago, Illinois. I specialize in spine. I have been interested in the effect of work on the musculoskeletal system for almost 40 years. I am publishing widely on issues related to the influence of lifting, twisting, other types of activities on the spine; sitting, standing. Published textbooks on occupational biomechanics.

DR. BARROS-BAILEY: Thank you. And as we welcome a new member to the Panel, we would also like to inform you and the audience of the resignation of Mr. James Woods. We wish Jim all the best in his future endeavors.

At this point we're going to go ahead and review the agenda for the day. And in order to assure completion of our September assignment, our daunting task, this meeting of the Panel will primarily provide us with the opportunity to discuss and deliberate the beginning stages of each subcommittee's recommendation. We will also hear from two member organizations, and look forward to

their insight and advice that they can provide us.

The Chair of the Mental Cognitive Subcommittee will be providing a presentation, Drawing Inferences; and later this afternoon from 2:30 to 3:30 we're going to have the opportunity to have public comment. Tomorrow we will continue with the deliberation and planning of future meetings, and then adjourn at noon. For those listening on the phone, I'm going to announce breaks so that you are aware of when we are not in session and when we are planning on coming back.

Since April the Panel has been very, very busy identifying information that will feed into the work of each subcommittee; and ultimately, into our final recommendations in September. And because there are new members in the audience, and those listening in might have been involved in previous meetings, I would like to draw your attention to the Panel's charter and to our mission. And we iterate that it is to provide independent advice and recommendations to Commissioner Astrue and the Social Security Administration as it -- on its plans

and activities to replace the Dictionary of Occupational Titles in the Social Security Administration's disability determination process.

The recommendations that are due in September will outline the type of occupational information that the Social Security Administration should collect, as well as recommendations on the type of classification system that the Agency should use.

The OIDAP is the second stage in terms of a larger project that considers the use of occupational information. And I will have the project director, Sylvia Karman say a couple words about that project. Sylvia.

MS. KARMAN: Good morning, everyone. Thank you, Mary.

One of the things that we think we would want to do, especially since new individuals join us by phone and in the -- in the audience every time we have a meeting, is to just go over a little bit about what our projects entails. We have a number of efforts underway of which the Panel is one large

feature of that, and we are, you know, looking at replacing the use of the Dictionary of Occupational Titles in our program and creating something that is tailored for SSA's use and SSA's needs.

Right now we have something where we're looking at short-term solutions as well as long term. The Panel is -- is convened, has been established to help the Agency assess how it should be moving forward with regard to the long-term efforts. So -- and they are largely research and development oriented.

When the Agency gets to the point in the process where we have begun to collect data and are able to analyze it, then the Agency will be in a position to make policy determinations about what might need to change, if anything needs to change with the policy. But the Panel will not be working on policy issues per se, although, what the Panel may be recommending and what our project team is working on would certainly, we're hoping, be helpful in informing possible policy development. But anyway, it is just something we would like to make

clear to people that we not here to develop policy.

One of the things that I think is also helpful is if I could call your attention to the road map, which is behind section one for those of you who have the materials. And first -- second red divider is the road map for Developing an Occupational Information System for Social Security Administration. This is basically, you know, an outline that shows what we're thinking the project would entail in terms of activities, you know, how the Panel is involved with the Agency. At what point the Panel would be involved with the Agency. What the Agency is doing, and who is doing what when.

So, for example, if we look under part one we will see right now we're developing a content model. We're also developing a classification system -- at least an initial one -- to get us started.

So SSA will -- you know, has proposed plans in working papers and presented them to the Panel with regard to developing a content model,

with regard to developing an initial classification system. And then, of course, as we all know, the Panel will be developing recommendations, has been working in several subcommittees to pull that together. Then the staff will take that information -- once the Panel has provided the recommendations to the commissioner, SSA will then determine how to move forward. And as we do that, staff will be developing content model classification system instruments as needed, and then we will be coming back to the Panel, back through SSA management.

So it's an iterative process whereby the Panel will be involved at every step as well as, you know, working closely with our internal SSA workgroup. So it's just a way of people being able to see where we're headed.

Also, we have provided an appendix to that road map that shows all of the meetings that we have held, and we're going to be also posting our background papers, working papers all of that material so that people can see what we have

provided to the Panel, and the materials that we've developed to outline where we're going to be moving next. So I think that's -- that's all I have for now, Mary.

DR. BARROS-BAILEY: Thank you, Sylvia.

If you notice the road map has been updated from the first couple times we've seen it. It is a really important document that has helped us put together a time line, as we will be discussing later today.

So thank you, Sylvia, for your work on that.

At this time -- well, at the April meeting we kind of expanded the role of the User Needs Subcommittee to include relations. And the Panel -- the creation of this subcommittee was to be able to not only look at the needs, but also to reach out to our stakeholders.

One of the first efforts has been to identify organizations who can provide us with useful input and information in terms of seasoned guidance about the current use of the DOT, and to

assist in identification of information currently used that is incomplete or non-existent, but it's vital in terms of the day-to-day operations -- in terms of the day to day operations of the Social Security disabilities -- Disability Associations, disability determination process.

So I would like to introduce Georgina Huskey. She is the president of the National Association of Disability Examiners who will be presenting to us this morning. As a member of NADE since 1992, Georgina has been involved with the Los Angeles chapter in several capacities and worked in many national committees, most notably being honored as Chair of the Litigation Monitoring Committee and the recipient of the Regional Supervisor's award in 2005.

She served as the Pacific Region President for three years, and she was the Pacific Regional Director for four years. During the 25 year tenure with the California DDS, she has held many positions, including that of Disability Evaluation Analyst, Case Consultant, Professional Relations

Officer, Quality Assurance Analyst, and Hearing Officer.

Georgina's material are in our binder. They are behind the next red tab that we were looking at under the -- behind the road map. Welcome, Georgina.

MS. HUSKEY: Thank you very much. Dr. Mary Barros-Bailey, interim Chair, distinguished and esteemed Panel members of the Occupational Information Development Advisory Panel. The National Association of Disability Examiners, NADE, appreciates this opportunity to submit comments regarding any gaps that currently exist between the occupation -- the occupational information available in the DOT, and that which the organization feels is necessary for the adjudication of claims in the SSA disability programs.

NADE is a professional association whose purpose is to promote the art and science of the disability evaluation. The majority of our members work in the state disability determination service known as DDS's agencies, adjudicating claims for

Social Security and/or for Supplemental Security Income, SSI, disability claims. As such, our members constitute the front lines of disability evaluation. However, our membership also includes SSA central and regional office personnel, attorneys, physicians, nonattorney, claimant representatives, and claimant advocates.

It is the diversity of our membership, combined with our extensive program knowledge and hands on experience which enables NADE to offer a perspective on disability issues that we believe is both unique and reflective of programmatic realism. NADE members throughout the DDS's, SSA offices, ODAR offices, and throughout the private sector are deeply concerned about the integrity and efficiency of the Social Security and SSI disability programs.

Simply stated, we believe that those who are entitled to disability benefits under the law should receive them. And those that are not, should not. Decisions on disability claims should be reached in a timely, efficient, and equitable manner. We believe that a current and comprehensive

vocational tool is essential to the correct disability determination at the earliest possible level of adjudication.

I also would like to begin, before I get on to my presentation -- to let the Panel know that the DDS examiner is responsible for everything in the case from development to determination. We must be able to make vocational analysis quickly and accurately to keep up with the workloads. He/she does not have hours to spend on each vocational analysis. And if the DDS, as a vocational specialist, he or she cannot analyze every single case that involves a vocational issue.

Also, many DDS examiners are relatively new on the job. The DOT replacement must be just as user friendly for the new examiner as for the vocational expert with years of specialized experience.

Okay. Status of the current DOT and why the DOT must be replaced. The current DOT was designed by the Department of Labor for their purposes not SSA. SSA adopted this tool for use in

disability adjudication. While not necessarily a case of trying to fit a square peg into a round hole, it often proved almost as difficult for the disability examiners in their daily use. And that was when the DOT was current. The last revision to current DOT is nearly 20 years old.

How have jobs changed in the last 20 years? How many new jobs have appeared in the last 20 years? How many jobs have actually become obsolete in the last 20 years?

Current DOT is very much obsolete.

Most DDS decisions are based on a medical and vocational factors. Three million initial claims are expected to be processed by the DDSs in 2009. A million reconsideration claims are expected to be filed in 2009.

Approximately 75 percent of the 3 million decisions -- or 3 million decisions of the 4 million will consider vocational factors in the final determination. The DDS goal is to make an accurate decision in every case.

Relying on an obsolete DOT makes accuracy

problematic. It does not make it impossible, but it does require more work for disability examiners and DDS vocational specialists to address such issues as to whether the claimant can return to past work or whether the claimant possesses job skills transferable to other work.

Automation has changed the way most production jobs are performed, making many of these job less skilled than before and requiring less exertion than before. Many jobs, such as a fast food restaurant cashier, require little thought. Today's cash registers do not -- do not require the clerk to enter prices or compute the change; the machine does that for them. On the other hand, these jobs are performed in high stress environments not acknowledged by the current DOT.

Current issues or gaps involving occupational information. Medical vocational analysis of claims is challenging when there is conflicting vocational information on the SSA-3368 -- which is the application everybody completes -- and the SSA-3369, which is the work

history. A claim could be erroneously denied if a disability examiner uses misinformation listed in Section three, information about your work, on the 3368.

When a 3369 is obtained, the detailed information on that form often conflicts with a more limited information provided in the 3368. A potential resolution to this issue may reside in deleting section three from the 3368 and relying solely on the 3369, and/or contact with the claimant.

An example of a gap that currently exists between the occupational information in the DOT and the SCO, which is the Selected Characteristics of Occupation, include the lack of rating of such activities as pushing and pulling, and definite guidelines regarding the type of reaching jobs required.

Jobs are coded in the SCO for reaching, however, the claimant is limited -- if the claimant is limited for only overhead reaching, unless that activity is apparent in the DOT description, the

claimant must be contacted to determine what type of reaching, including how frequently, with one or both extremities, and for what job duties, et cetera. This additional step may be eliminated in some cases if the job coding was more definite.

Another gap in the coding of the jobs in the DOT is that it is left to the judgment of the examiner -- many of whom today are very inexperienced, and all of whom are overworked -- to realize a job could involve exposure to non-exertional factors such as an environmental condition that is coded as not present in the SCO.

For example is the job of a yarn winder. This type of job can expose the worker to excessive flying particles, such as lint, dust particles, et cetera; but coding in the SCO under environmental condition factor indicates atmospheric conditions are not present.

When they devised the SCO, the Department of Labor rated non-exertional factors only when the activities are critical. For example, when there is -- when their presence is more than routine in

amount, or when present to a considerable degree. However, it would be inappropriate to deny the claimant -- back to the job of the yarn winder -- if he or she has severe respiratory impairment on the basis of that atmospheric -- on the basis that atmospheric conditions were coded in the SCO as not present.

The same holds true for the claimant with a severe respiratory impairment whose past work was that of a cleaner, housekeeping or a cleaner, hospital. Neither job is coded in the SCO as involving exposure to atmospheric conditions. While exposure to fumes, odors from industrial chemicals used in the cleaning process may not be detrimental to the unimpaired worker, an individual whose respiratory ability is already compromised would be at further risk if consistently exposed to such irritants.

The category of hazards included under a number of categories under environmental condition factors, the most common of which appears to be proximity to moving, mechanical parts, and other

environmental conditions is another non-exertional factor that is coded as not present in many jobs that would be hazardous to an impaired individual.

We think the requisite issue here is that more definite coding of these non-exertional factors would be beneficial in any future occupational information system, especially when analyzing job performance by impaired individuals.

Another issue regarding coding of non-exertional factors would be to make the coding consistent with the way the limitations are indicated on the RFC, especially with regards to environmental limitations. Does avoid concentrated exposure indicate on the RFC -- indicated on the RFC equate to the rating of occasional as coded on the SCO?

It has been the practice of most DDS -- DDS's to consider that if there is an environmental limitation indicated on the RFC, no matter if it's to avoid concentrated exposure, avoid even moderate exposure, or avoid all exposure, and a job is coded "all" in the -- "at all" in the SCO for that factor, the job should be precluded, for even incidental

exposure could be detrimental to an impaired individual.

Functions of the replacement DOT. Searchable data that would allow disability examiners to cross-match specific skills from claimant's current job with other jobs involving that same skill or skills.

A section for potential transferability to lower occupational bases. DDS having informal transferability for common occupations. It needs to be user friendly. It needs to be a search engine for keywords or phrases. Performance that does not impede the speech, use of other software running simultaneously.

And I want to address this. When we go into the OccuBrowse, for instance; and the analyst is in that function, the rest of the functions are -- you can't use them. So you know, we need something that is user friendly with other things.

Okay. Occupational information. Addition of common jobs found in prior work history. For example, handyman, multiple trades, but not focused

specialty, no license. This handyman is not found in the DOT, which is amazing. Traveling computer repair person, such as the Geek squad workers at Best Buy.

The replacement DOT should separate standing and walking. These are two different physical attributes requiring different abilities by the claimant. Use of major joints for repetitive motion should be specified when necessary.

Computer based jobs, example, web designer, internet service, et cetera.

DOT should be written in work terms meaningful to disability examiners. The DOT work history and the DDS residual functional capacity, or the RFC and MRFC, should work in concert together. Instead of a band playing together, we have an arrangement that has often been described by disability examiners as three pieces of music being performed in three different tempos by musicians playing on broken instruments and led by a deaf conductor.

New DOT should specify stress levels of each job performed under ordinary circumstances.

This is a critical factor in determining if the claimants with mental impairments can return to prior work activities or perform other jobs in the national economy.

Replacement DOT beginning or alternatives. The Job Browser by SkillTRAN available via the intranet and SSA digital library. This tool already allows disability examiners to research a job to discover all the skilled competencies required to perform the jobs. And I have three or four examples listed here.

SSA can build on these tools to add the additional factors. For example, expanded list of exertional demands and SVP, or specific vocational preparation, level of each job; searchable database for matching skills, et cetera.

In the attachment I have the short version of the four jobs that I listed, the claims adjudicator, the nurse, general duty; the secretary, and the cook and short ordered cook. And in my attachments what I have done is I have listed the long version, and then the SkillTRAN will list the

shorter, which is what is in my -- over here.

For instance, the claim adjudicators, here is the general description. But the skills and competencies is investigating. So if an analyst or an examiner was suppose to punch in the skill into this tool and maybe all kinds of jobs can come up. It's very difficult in many instances to match that specific job to the DOT or anything that we have. So if we were to just type in the skills, maybe something would come up that would be more readily identifiable for the examiner.

Okay. So here is the long version, claims adjudicator; and the short version says the skills and competencies are investigating. That would be obtaining and evaluating data about persons, places, and incidents for purposes of -- such as solving criminal cases; settling claims; estimating credit risk; determining the qualification, integrity, and loyalty of people; assessing eligibility for social-service-assistance program; and ensuring compliance with laws and regulation.

That person advises, enforces, inquires,

inspects, interrogates, interviews, questions, scans and search. So there are some specific skills. And as you can see in the short description, you know, there is all kinds of jobs that fall into that description that can be pulled up with skills.

Same thing for nurse, general duty. The long description is in my attachment. The short, the skills and competencies are in healthcare and medical. They treat people and animals with physical and mental problems. And they do bandaging, bathing, diagnosing, disinfecting, examining, exercising, injecting, inoculating, interviewing, investigating, massaging, monitoring, prescribing quarantining, rubbing, taking pulse, and treating.

The next one is the secretary with skill competencies as verbal recording and record keeping. What they -- what this individual usually do, their skills is preparing, keeping, sorting, and distributing records and communications, primarily verbal in character; but including symbol devices to communicate and systemize information and data.

Some of the things that they do is

addressing, checking, collating, counting, editing, filing, listing, locating, mailing, marking, posting, punching, reading, routing, searching, segregating, selecting, stamping, taking dictation, taking minutes, typing, verifying, and writing.

The last one that I have listed is the cook, short order -- and this is the way it appears in the SkillTRAN.

MR. HARDY: Can I interrupt you?

MS. HUSKEY: That's okay.

MR. HARDY: If it's okay with you. I know you have a flow going.

MS. HUSKEY: No; no. No problem.

MR. HARDY: I am curious -- I'm looking at the Job Browser skills example. What I struggle with often is a definition of what a skill is. And I'm looking at some of these examples, and looking at, say, the secretary. Is stamping a letter a skill? Is mailing a letter a skill? Or the cook, short order, would you consider basting a skill?

So I'm stepping back, because I hear what you are saying. If I understand the end user's

needs properly, you need to know what the skills are.

MS. HUSKEY: Right.

MR. HARDY: Are those truly good examples of skills? Or is there something you would assert about those definitions?

MS. HUSKEY: Okay. The actual skills of a secretary would be verbal recording and record recording; but in their -- in their work activities they would have to do all of this functions.

MR. HARDY: So those lower things, you would not consider those a skills?

MS. HUSKEY: Right.

MR. HARDY: There would be a line between preparing, sorting, and distributing; and then going down to mailing, same thing.

MS. HUSKEY: Exactly; exactly.

MR. HARDY: So for you the skill is truly up here in what's almost a description?

MS. HUSKEY: The skills are the competencies of a supervisor, would be verbal recording or record keeping. But in the way that

they perform that job, all of these other things would be necessary, like the preparing, the keeping -- and you know, keeping records, sorting, and distributing.

You will see a lot of -- you know, a lot of lower clerical jobs will also have some of these other things, okay. But if -- a secretary would be in the national economy as to perform those duties.

MR. HARDY: Okay. The duties.

MS. HUSKEY: Right. Right.

What the analyst would like to do is type in a skill. When a claimant describes a job and we say, okay, what was -- you know, what skills did you have, and that's what they would -- what they would tell us is what we would like to pop in, and then see what comes up.

Okay. Secretary, of course, would be -- well, in some industry like the legal industry, this would be a highly qualified individual. Secretaries in other jobs may not be that, you know -- you know, may not require all this -- you know, it would be higher skills, lower skills. So it depends what

industry they come from, but if you see -- where is my examples?

MR. HARDY: I guess I just want to make sure I'm following you. Would like to be able to type in something that says sorting, and distributing records; and from that flow out any other occupation that has that in there?

MS. HUSKEY: Exactly; exactly.

MR. HARDY: And you are not talking about the things that build up or feed into that skill?

MS. HUSKEY: Right; exactly.

MR. HARDY: I want to make sure I have that clear.

MS. HUSKEY: Exactly. If you see -- when you type in secretary in the job SkillTRAN, what pops up is automotive service cashier secretary, insurance secretary, sales secretary, secretarial stenography, secretary senior, secretary executive, administrative assistant. So there is all kinds of jobs. Then it lists all these things.

And then what the SkillTRAN browser does is it summarizes the skills, and then the things

that they're asked to do under the secretary general type thing. And some of the -- you know, some of these secretaries that are listed up here may be doing some of the things, but generally, that's what it does.

MR. HARDY: Thank you. Sorry to interrupt.

MS. HUSKEY: No; no. I understand. I understand. This is actually my opinion, a really neat little way of doing vocational analysis.

The problem comes in the fact that most of the examiners in the DDSs as of today have been trained in the DOT. And you know, when all these other things are available and you go into -- and you ask an examiner, well, what do you mainly use? Oh, I use the DOT. Why? Because that's how I was trained. So given that, you know, it becomes -- it really -- the vocational part of the examiner's job right now is a very huge job. Go ahead.

MR. HARDY: Yes. Extrapolate a little bit. If you are using this -- typing in a skill to get an occupation, it is basically what you want to

do. You want to type in keeps and sorts records; and then up will come your listing of occupations.

MS. HUSKEY: Exactly.

MR. HARDY: Then from that, you want your examiner to be able to go through and pick up the past relevant work.

MS. HUSKEY: That best matches, exactly.

MR. HARDY: Okay. So you wouldn't be using this for a skills transfer. It would be just be for a search.

MS. HUSKEY: The SkillTRAN does not give us a transfer, exactly. So you know, we do need -- this is when it comes to exactly what job is this claimant trying to communicate to us, you know. And that -- and it's really interesting, because they may call themselves a secretary. When it comes right down to it, you know, it really doesn't match what is available to them. So then we have to either call a claimant and figure out, okay, what pay are we going to place you in.

If you are using the SkillTRAN, for instance, and they are telling us that they file, et

cetera, et cetera, we might be able to -- okay, so you were a secretary. Then, in what industry did this happen? So -- because like I said, the secretary job may change the definition from industry to industry, okay. And the level of skill of a secretary may change from industry to industry.

MR. HARDY: Sorry to interrupt you. Thank you.

MS. HUSKEY: No; no. This is just an alternative how to -- especially when we are now looking, trying to match a claimant to past work. You know, okay, where exactly do they fit it? Transferability is completely different. Okay. Yeah.

Did I answer your question?

MR. HARDY: Yes, ma'am.

MS. HUSKEY: Okay.

Okay. The other alternative that we have right now is the OccuBrowse, which offers a potential alternative to the DOT. And with the incorporation of additional information, could become an even more valuable and practical tool for

the use of the disability examiner.

One of the beneficial aspects of the OccuBrowse is that it allows for scanning of related job title in the list of jobs that follow the one entered in the search. This feature, as well as the ability to enter key words in the search engine, would be an asset to any future occupational reference materials. The ability to scan related jobs in a list that are closely related to the claimant's job would be a very effective tool in a transferability of skills analysis.

Another useful feature of the OccuBrowse is that it includes a category of situations in the requirements section. The information it contains assists the disability examiner in determining the feasibility of jobs for claims -- claimants who are assessed with mental limitations.

The OccuBrowse also lists undefined related titles which can steer the disability examiner to a more accurate job title when identifying the claimant's past work as preferred in the national economy.

Questions to ponder. It is difficult to make a defensible argument that skills acquired from a claimant's current work activity would be transferable to other jobs that have a date last updated in the 1970's and 1980's. Those are supposedly closely related jobs that we are citing in our transferability analysis. Unless we can cite more current jobs to which a claimant's skills are transferable, it may be more practical to eliminate the concept of transferability from the program. Of course, this would require some revision of the vocational rules tables as well.

If the transferability concept is eliminated, we would then consider the claimant's description of past work in step four of sequential evaluation, totally avoiding the issue of citing a DOT counterpart. This would allow an updated or replacement DOT, or other occupational resource system to be utilized only in step five for citation of other unskilled jobs in denial decisions and for citing the vocational rule that directs the final determination.

By accepting the claimant's description of past work when making the function-by-function comparison to the RFC and/or the MRFC, we eliminate a cumbersome task of identifying the jobs in the DOT. This would appear to eliminate countless erroneous job identification issues and allow us to abide by the concept that the claimant is the primary source of job information.

Education as a vocational factor. In today's rapidly changing technological job market, does a high school diploma or college degree earned in the distant past, even ten years ago, truly add any vocational advantage to the claimant?

I also have an addendum of occupational information. We find that in the DOT -- and I mentioned the reaching requirements. There are typically four reaching levels to be considered. Under the shoulder, at the shoulder, above the shoulder, and above the head. This is essential to a disability decision, and this is something that we're not even considering right now, because it's very difficult, and nobody bothers to explain it to

us. We actually have to call the claimant.

For instance, a claimant that cannot reach in all directions, as the RFC says, either above the head -- let's say in all directions. If the claimant is restricted in reaching in all directions, can a claimant that is doing sedentary work do that job? Because you need to reach at all times. Can this be done with one extremity or both extremity? All of these things need to be mentioned in the job when jobs are compiled.

The DOT does not show specific handling requirements, basic grasping, forceful grasping, twisting at the arm -- at the wrist; is the arm also required.

Fingering requirement -- and this is pretty major now with carpal tunnel syndrome, especially now with so many technical jobs where you are using your hands all the time. Pinching, keyboarding, bilateral requirements. Is it bilateral or unilateral? If you have a person that literally cannot use their hands due to those things, you know, are they able to perform the work?

Are they able to work at all?

Environmental factors that I mentioned very heavily in my presentation, such as fumes. Such jobs as sewing machine operators. It is very difficult to evaluate a job of a sewing machine operator, because we need to know the size of the machinery. How are the lower extremities used. Is there foot pedals? Is there just a knee? Is there -- you know, so we need to know exactly what a sewing machine operator -- the size of the machine, the type of the machine; and what is it that is need to perform that job in terms of extremities.

And definitely the stress issue. The stress issue level has to be specified, and this is something that is not found in the DOT. Can these people work in teams? Can they work around people? These kinds of things are essential to determine whether the person can return to the past relevant work or not.

And in closing, the old drunk staggers home one night and literally falls on the floor as he opens the door to his house. His wife glaring

down as he is laying on the floor demands to know what he has to say for himself. The old drunk looks up to her and replies, I have no prepared remarks; but I will be happy to take questions from the floor.

DR. BARROS-BAILEY: I think we have time for one question.

DR. WILSON: I would just very much like to thank you for your comments. It has been very helpful. If you can tell me anymore about what you consider user friendliness would be. I know we heard a little bit about searchability and the program running not being a resource on the computer; but are there other kinds of things that you think of when you say "user friendly"?

MS. HUSKEY: You know, I asked a lot of people before I came today, I said, okay, in your dream, how would you like to do this occupational research data? And they said, if we could type in -- let's say, a claimant tells us that they, you know, investigator, going back to that. Type that skill in and see what comes up. You know, what

kinds of jobs come up with that. And they said that would be really helpful, because that would not only help them look or connect with the present or the past relevant work, and maybe even help them in doing transferability of skills.

DR. WILSON: Would you like it at all if the computer could help you with that?

MS. HUSKEY: Oh, yes.

DR. WILSON: That it would ask you a sequence of questions that might guide you as opposed to just having you do the search yourself?

MS. HUSKEY: Oh, that would be wonderful; yes.

DR. BARROS-BAILEY: Thank you very much. That was very helpful. As we're going through this process, it is also helpful if there are other ideas that you have even after you leave, anything that you would like us to do.

MS. HUSKEY: Excuse me. Likewise, if the Panel has any other ideas that they would like us to answer to, you can reach me by e-mail, and I will be glad to get you the answer promptly.

DR. BARROS-BAILEY: Thank you. And if you can send our thanks to the national association, that would be great as well.

MS. HUSKEY: Thank you.

DR. BARROS-BAILEY: Okay.

Next, we would like to introduce Trudy Lyon-Hart. She is presenting to the Panel on behalf of the National Council on Disability Determination Directors, NCDDD, a voluntary managerial association composed of the directors and top administrative staff of State and Territorial Disability Determination Service agencies located throughout the U.S.

Central to NCDDD's mission is provision of the highest possible level of service to persons with disabilities. The organization's goal is to provide leadership through dialogue with Social Security and other organizations interested in protecting the rights of people with disabilities, and through encouraging policies that best serve the public interest in accomplishing the mission of the disability program.

Ms. Lyon-Hart is currently the secretary of NCDDD, and director of the Vermont DDS where she oversees the state's Social Security disability determinations at the initial and reconsideration levels, as well as continuing disability reviews and the first appellate level hearings of those reviews by disability hearing officers.

Trudy, welcome.

MS. LYON-HART: Thank you. Thank you, Mary. And thanks to the Panel for inviting the National Council of Disability Determination Directors, formerly known as NCDDD to present our perspective and ideas to the Panel today. My presentation reflects the input of the NCDDD membership, that is the DDS directors, administrators and management staff across the country.

Despite the pretty tight time frame 34 DDS's responded to my call and provided the material that I have compiled for this presentation.

I would like to take a minute first as part of my introduction to describe the context, to

describe the DDS reality on the ground. As you heard from NADE, we process a high volume of cases. Our job is to get them all done accurately and quickly. The typical disability examiner processes about 500 to 600 cases a year.

Doing the math, taking them -- using the number of hours typically worked in a year, that's less than four hours per case on average. In that time the examiner has to do -- as NADE told you -- has to do basically everything to developing and determining that case. They write the medical evidence. When they don't get it timely, they have to follow-up. They have to call and clarify information from sources. They have to read and analyze well over 100 pages in most cases of medical reports and functional information. They have to analyze RFC assessments single decision maker states. They even write those assessments. And then they do the vocational assessment.

Now, not all cases, of course, require an RFC and a vocational assessment, but the vast majority of them do. Then they will write the

decision and the notice of the claimant.

That's a lot to do in an average of less than four hours per case. And it doesn't include the time it takes an examiner to -- to manage their case load, which is usually 150 or more cases at all stages of development.

So even when DDS's have full time vocational specialists, they don't have enough hours to handle every vocational analysis that must be done. The reality is the examiner's do most if not all of them. That's today.

The workload is increasing. Our baby boom examiners are retiring. We are hiring new examiners with little experience, and they take two years or more to train sometimes; and it's, you know, a big investment of intensive training and mentoring.

Given this context, you can see how vitally important it is to have vocational assessment tools that are quick and easy to use, and that provide complete, accurate, consistent information that the examiner needs to make the right decision.

I was asked to address several issues in this presentation. The first is, what occupational information do we need to adjudicate claims? We need a compilation of jobs that currently exist in the national economy. We need job descriptions that are consistently structured and that list duties, work processes, tools and machines, and required skills.

We need the functional demand for each job to be described in a way that corresponds to SSA defined physical and mental residual functional capacity, RFC assessment categories and measures.

We need to be able to quickly find jobs with similar duties, tools, machines, skill sets, and industry for accurate and consistent transferability assessments. Where the transferability of skills among the subset of jobs has been established, these list should be readily available to all adjudicators, and their application should be the official policy for all adjudicative levels.

And we need lists of unskilled jobs at

each exertional level that exist in significant numbers in the national economy that the adjudicators may reference in determining jobs to cite in other work denials where skill transferability is not material or doesn't exist.

So there are gaps, obviously, between the old DOT and the SCO, and what is needed to adjudicate claims. The two major issues are the outdatedness of the DOT and the SCO information not matching with the RFC information that we -- we measure.

Many jobs are missing in the DOT. Just a few examples, the computer field, communication, medicine. I have been told that they can't find a Walmart greeter in there.

And composite jobs have, in all likelihood, multiplied as companies have downsized and done more with less in these years. This may affect the number of unskilled jobs in the national economy, as these jobs have been incorporated into the duties of jobs that also require more complex tasks. And an example in our -- in most of our

offices is that our managers now do things like open the mail, as well as manage. We don't have the same kind of clerical support we use to have.

The DOT also provides few descriptions for those assistant managers, working supervisors, and lead workers that oversee shifts, but may not have the full managerial responsibilities of hiring, firing, and other types of duties. Some DOT job descriptions are obsolete. Either the jobs are performed differently now or they don't even exist.

The SCO provides limited information about the functional requirements of the jobs, often merely whether or not the function is used to a significant degree, without further specification. So more information is needed to perform the function by function comparisons to identify the jobs within an individual's residual functional capacity assessment.

Any of you can take an RFC form and compare it to what information the SCO provides, and easily see the discrepancies, so I will just name a few examples and NADE gave you some of these as

well. Things that are not well defined and described for us include alternating standing and sitting positions, whether a job can accommodate that kind of ability to move about, and how frequently.

Various postural requirements, the reaching requirements. NADE went into that in pretty much depth. We need to know the height of the reaching that's required in the job, the direction, and whether it can be done by one arm or requires both arms to do that kind of reaching. Also, one arm handling and fingering is also very difficult to tell from the DOT and the SCO.

I will skip some of the other examples that you have in writing, but I want to highlight the details of the mental demands in jobs that are also not well defined, so that we can match a job with a mental residual functional capacity assessment.

We need to know things like the level of the task complexity, how much independent judgment is needed, how many steps in a series of tasks a

person has to do. How fast paced and high pressured the job is. The types of interpersonal interactions, the frequency and adapt -- you know, adaptability. How many changes does a person have to be able to adapt to easily to do that job. Also, can the job accommodate variable schedules and extra work breaks that might be needed not only for people with mental impairments, but with physical impairments that have a component of fatigue or pain, or require like bathroom -- extra bathroom breaks, that kind of thing.

In short, the requirements for specifying very detailed information on our RFC assessment that -- the policy for that has been to increase that level of specificity over the years. And the SCO just has not been able to keep pace. We need the two to be aligned.

So what new information do we need? I have already addressed the need for currency and the correlation with the functional demands with the RFC and the SCO, or whatever replaces that.

Taking a broader view for a moment, there

needs to be reassessment of the vocational rules and the occupational basis the grids represent. The number of jobs in the national economy that these grids represent as the sedentary, light, and medium levels, given the changes from a manufacturing to an information and services based economy, and the technological changes that have transpired since the vocational grids were created.

The current vocational rules were created for a different society and do not take into consideration today's reality. That reality includes older workers remaining employed longer. The technological advances have caused an overall shift to lighter, less English-reliant work. And we wonder how many unskilled sedentary jobs currently exist, and what exactly do they require in the way of physical and mental abilities?

There also need to be ongoing assessment of how long skills in the various occupations remain viable, aligning SSA policy for how far back in the claimants' job histories adjudicators must go in determining the relevance and transferability of

jobs.

Another question is what kind of platform should this new occupational information tool use? And the DDS community recommends an electronic database kind of platform. It should be searchable by keyword, skills, tools, machines, anything else that you can think of with progressive search options giving the adjudicators the ability to further narrow the search as they go forward; or if it comes out too narrow, too broad in that.

It should have cross-references to synonymous or closely related job titles. It should have ability to thesaurus the similar terms and titles, and a glossary of tools, and machines, and other technologies with which the typical adjudicator many not be familiar.

It might also provide other methods to help adjudicators really understand the work that the claimant has done or what kinds of jobs they are choosing to say that the claimant can go back to, things like videos of how machines -- video clips of how a machine is operated, what it looks like might

be very helpful.

This tool should have the capacity to systematically retrieve lists of jobs to which skills could be potentially transferred once past work is identified. It would be great to have links at the bottom of -- you know, when you are looking at this information so that you can get right to jobs that might work for your -- for your claimant, and be able to then refine that lists by, you know, the various RFC limitations the claimant has, the age and education, that kind of thing.

We would like to see a structured database -- structure to the operation of the database that would guide users through the steps of vocational analysis and provide a format for them to explain the decisions they're making as they go through the process, and why they ruled out this job nor ruled that job in, et cetera. How they transferred skills or decided that adverse profiles were not met, et cetera.

Then, if that can be built into the tool, then it should interface with the electronic folder

so that the database search findings and the adjudicators analysis of those findings become part of the file in a standard format.

We need SSA to develop a tool and make it easily updatable and supported by a routine, ongoing process of, you know, regular updating. We don't want to be 20 years from now looking at what this Panel helps to create and say oh, God it's all out of date. We have got to update it again. It should be something that we can continually update, and that it continually adapts to any further policy changes that SSA will make over the years in such areas as, you know, what we do with RFC assessment and vocational analysis.

It should be user-friendly, and that partly means, besides the things that I have already mentioned, that, you know, should involve as little screen changes and toggling as possible. Have it be visually easy to follow, bulleted lists sometimes rather than a paragraph of things. Incorporating skills and other information that is now kind of found in a lot of different places, but if it can be

all in one basic tool.

We were asked to identify available resources that SSA might use in developing the -- a tool for the 21st Century. So we -- we know of the following, and I'm not, as an administrator now -- although, I was an examiner in the past and used the DOT and SCO; but I have not personally used a lot of these tools. But the input that I received was there is OccuBrowse, the Occupational Outlook Handbook from the Bureau of Labor Statistics web site, Job Browser Pro by SkillTRAN.

Many adjudicators found the "less than" search function of the Denver DOT useful, although, we're not using the Denver DOT now, as I understand.

O*Net has promising features, but it lacks some of the RFC categories and measures of limitations that we need; County Business Patterns. Then, of course, we have vocational experts. Then there may be other places that we might go for information, such as any assessment tools that rehabilitation or occupational therapy industries have produced; or industries themselves may have

developed comprehensive job specifications and they may have a process for updating them; and there may be the potential for further collaboration with DOL and voc rehab.

There is a smorgasbord of various tools, and the most user friendly thing I can think of is that we need one tool that the disability adjudicator can go to and quickly do their vocational assessment through.

Before I close some members of my organization offered a few related suggestions, and I will just, you know, identify quickly. One was to revise the vocational report form, the 3369, to ask claimants better questions about job descriptions, functional requirements of those jobs, and the skills they use; and to devise -- form those questions more in line with the RFC categories and measures. To remove yes/no questions that don't really get at the level of detail and descriptive information that we need.

Another recommendation was to provide comprehensive -- to provide the DDS a comprehensive

training curriculum for all adjudicators on the use of any occupational information tools. As I mentioned, you know, we don't really have vocational specialists that can do all of these. We are using adjudicators, and many of them are new and inexperienced to do these decisions, and we really need training. As NADE mentioned, people use what you train them in. So we need to train them in all the tools.

If a project is done in stages -- if the development of the database is done in stages, we recommend trying to get to the most frequently -- just most frequently worked jobs first. And, you know, you can find that out by probably assessing what people put on their 3369's.

Another recommendation that a couple of members suggested was possibly expanding the listings and using some demographic information to devise listings similar to the way some listings have function built into them. So that we could possibly -- if we're going to allow a person anyway in a longer vocational assessment form, could we

find a way in some instances to make that a listing level decision that would be quicker and easier to do?

In closing, this project has exciting possibilities. I was really excited to be asked to do this, and to work with you. It has the potential to improve the consistency and quality of vocational analysis and disability determination across the national program. It may be -- it may have costs and time and effort that have to go into updating the data, and creating a smart kind of platform, and we hope that that will now be prohibitive, because it's really critical that we develop such a tool and soon to keep the disability program valid, and our determinations fact-based in the 21st century.

SSA needs to act soon, since much of this data is obsolete and the available tools do not meet the adjudicative needs or provide the supports necessary for us to process the burgeoning workload in a timely manner with a changing staff and new staff coming in.

That is basically my message. Thank you,

again, for the opportunity to provide the input. I will take any questions at this time.

DR. BARROS-BAILEY: Thank you, Trudy. We do have time for questions, Shanan.

DR. GIBSON: First of all, I just want to thank you. This is the most comprehensive list we have had from an end user regarding needs and wants. It's been very enlightening. So thank you much.

Also, one of the things you mentioned, we ask you to expand just a bit, if you don't mind; although, it's probably not what you were asked to report on. You have given us a very detailed run down of the things that are on the vocational information side, the tools you use. And you mentioned that frequently the language of the vocational assessments tools does not correspond to the language of the people side RFC tools.

Could you speak for just a moment regarding the quality of data you receive on the person side that's utilized in those two RFC forms? Because one of our goals will be, obviously, to have them better work together.

MS. LYON-HART: Just let me make sure I understand your question. You want me to speak about the information we get from the claimant?

DR. GIBSON: The medical.

MS. LYON-HART: The medical information, and how that corresponds to the RFC assessment, is that what you are asking me?

DR. GIBSON: How it more corresponds also to the vocational information that you are trying to marry to it so that you can make your determination.

MS. LYON-HART: I'm not sure I get it.

DR. GIBSON: Do you like the RFC forms?

MS. LYON-HART: Do I like them?

DR. GIBSON: Do they give you the information you need in comparison to the work information?

MS. LYON-HART: In comparison to the work information. Obviously, you can take and make changes either way. I mean, you can change the RFC form to better match the existing types of job information we have.

You know, it's really important to us that

we give each applicant a very fair decision. So I tend to like the trend that took place in the last 10, 20 years, getting into more specifics of what a person really can and can't do and what that is, and then trying to match that to the job. I think that's a very fair way of doing it. It is not easy because many things impact what a person can and can't do.

You know, pain levels are experienced differently. The same x-ray findings. One person can be walking around just fine with that disc misalignment, and another person isn't. Fatigue can affect people, and we do have to consider motivational factors for a person and what they do. It's a very difficult job that disability adjudicators do in that less than four hours per case.

So -- and obviously, that's an average, you know, if you have a difficult assessment you don't set it down and say well, I only have 20 minutes to do this and that's all I'm going to do; but they have to be juggling everything and getting

the easier cases out quicker and ones that don't require them -- but I'm getting off.

How would I -- I definitely think that the 3369 information is not -- those questions are not tailored well for what we really have to do with our assessments. I would like to see more questions -- better questions not only about what the person did in their job, but also questions about what they feel they can and can't do now that are tailored more to the RFC form, which I guess I think is pretty good.

We're required to -- I mean, it could be better. It could ask more specific questions. Now, we're required to remember to describe exactly how much alternates the sitting/standing the person can do or to describe the reaching. It can trigger -- there are issues where a doctor doesn't necessarily -- or a single decision maker doesn't necessarily remember to explain it in as detailed a fashion as we need, then there is back and forth. That is not efficient.

You know, basically, it's a pretty good

framework, but I would like to see the vocational report and the questions about what the person can and can't do, be better aligned with that; and then also change the -- or add to the vocational information. Does that answer your question?

DR. GIBSON: It gets very close to it. Thank you.

DR. BARROS-BAILEY: Thank you. Gunnar.

DR. ANDERSSON: My question is tangential, but how many of your decisions are appealed, and how many are changed on appeal?

MS. LYON-HART: I don't have that off the top of my head. I tend to think that Social Security should be able to provide that to you probably. I would hesitate to just give you an off the top figure. I know my own state, but Vermont is very tiny and may not be, you know, exemplative of the entire nation.

In my state right now we're running on -- our allowance rate is between 45 and 50 percent usually. I don't have an idea of how many of the denials actually are appealed; but of those appeals,

our reversal rate, you know, on our own first decisions varies. I mean, I have had months where I have 25 to 30 percent. My last month was 11 percent. So it does vary, and they're a lot of factors there that would influence that.

Some of the factors are the better the initial decision, the less likely it is to be overturned, although, things can change. You can get more information, or the person's impairment may not have improved as expected, or this time they may go to the consultative exam they missed the last time.

Also, the allowance rate, even at the initial rate, they're a lot of factors that go into that that may vary from state to state. What we have been finding, you know, a couple of years ago we were running an allowance rate at about 50, 51 percent, and we have seen that slip a bit.

The anecdotal information I hear from the people who are looking at these cases, is that with the economic downturn we are getting applications of people with probably less severe impairments who

just have lost their jobs and can't get another job, and are looking anywhere for help at that point.

So that tends to yield -- because, of course, we don't make the requirements easier, it tends to drop the allowance rate a little bit.

DR. ANDERSSON: The reason I'm asking, actually, I have heard that the numbers are fairly substantial. And I'm just wondering whether or not on appeal you get new information -- which you probably do -- and whether or not that information is more related to the impairment than it is related to the patient's job.

MS. LYON-HART: Okay. That's a good question. I think, yes, for the most part we do get more information. Most of it is probably medical, but we may expand on the vocational information as well. Particularly, we are instructed that, you know, if we make every reasonable effort to get the detail from the claimant, but they don't respond, then, we do an insufficient evidence denial. And on the recon we would want to try to -- once more to get that information, and the person may be more

forthcoming.

So I think we do -- we do try to make sure that we do have a good vocational history developed, especially at the recon. It should be done at the initial. We don't want to focus all our efforts at the reconsideration. We want to allow people as quickly as we can. They deserve it; or make the right decision if it's a denial. But we do get more information in both areas, I would say.

DR. BARROS-BAILEY: Sylvia.

MS. KARMAN: Yes, I just wanted to let the Panel and Trudy know that we will provide the information with regard to the national appellate rate and allowance and denial rate. We will get that information as soon as we can. I don't have it on me exactly. I want to be correct.

And the other thing is, is that in response to the point about -- Gunnar's question about what changes at the appellate level possibly, you know, where we need more -- you know, is there a change medically? Is there some other information that's brought forward about vocational issues

versus medical issues? One of the things we're doing -- our project team is about to begin a study that will get at not only the types of jobs that claimants have when they apply for disability, so we can do just as your organization is suggesting, we can focus our attention initially -- especially working in stages, that we want to get those jobs first that are most frequently found in our claimant population. But we're also going to attempt to pull information about the vocational input, the medical vocational input at the initial level for the DDS, and at the appellate level in ODAR, so that we can see possibly where the change is.

What are we looking at? What is Social Security -- when we issue a denial, what vocational input did we use? What job did we cite, for example, as examples of what the person has for remaining function to be able to do? So we're hopeful that that information actually will answer his question.

DR. BARROS-BAILEY: Thank you, Sylvia. Deb.

MS. LECHNER: Does it ever concern you that the information that you are getting -- excuse me -- for the RFCs or/and the vocational histories of the individual is largely self report, or inferences from medical data?

MS. LYON-HART: Yes. I would be very concerned if we kind of dropped the step of finding their job as it's performed in the national economy, for example. Certainly, if we dropped that, people could increase their -- what they report as having done. We don't really spend a lot of time, you know, verifying that. Especially if it's 15 years ago, would be almost impossible to verify.

I do think that it helps to -- a lot of the functional information that we use in making the RFC has to be -- has to be consistent with -- is self reporting. It has to be consistent with things that the doctors tell us. It doesn't have to be perfectly consistent, but, you know, it has to be supported by information that comes from the medical reports. And one of the reasons that it takes a long time to develop a case is because we're trying

to gather as much information as we can as sort of a broad view, and the perspective of different treating sources and employers, and that kind of thing.

We will talk to employers, especially with mental impairments, about how a person functioned on the job and where they might have had problems, especially if they had unsuccessful work attempts. You know, what were the problems? And that kind of helps to verify what the person might say.

Does that answer your question?

DR. BARROS-BAILEY: Tom.

MR. HARDY: You said something that caught my interest. You were under new information needed. Ongoing assessment of how long skills and various occupations remain viable? I think that's a fascinating question. I'm heading the Skills Subcommittee, so my attention is very much focused on that.

In my mind I think I know what you are saying. I would just ask you to expand that. Give me an example or two to make sure I'm tracking

longer.

MS. LYON-HART: Okay. Well, take the disability adjudicator position. Someone who last performed it seven or eight years ago has never worked with the electronic folder. That's a whole skill subset that they don't have. The jobs -- maybe they were using a different -- earlier -- you know, the job back then may have used the different types of -- we had more specific guidance.

We had charts of well, if your pulmonary function test findings are like this, then, you can do light work. We had charts like that back in the '80's for instance. It made for more cookie cutter decisions. It made for less analysis. The job may now require much more kind of real analysis than it use too.

Jobs change, so just because you did this job five or six years ago, your skills may now be outdated. Let's see. You know, so that it might be -- the person really might not be able to go back to that job, you know, because they just -- the job has grown and they have not, even though you have

got a same job title. Or the job may be the same, but the fact that you haven't done it for five or six years, you know -- some jobs are like riding a bicycle, but not all jobs are. So there may be that component too. Did that answer?

MR. HARDY: Yes.

DR. BARROS-BAILEY: Thank you. I have a question that's kind of related. Do some DDSs have or have they developed a transferable skills worksheet -- analysis worksheet? So there are specific tools that have to be developed at particular DDSs to try to deal with some of the issues that Tom was asking about.

MS. LYON-HART: I think so. You know, not having polled my people for that, I'm pretty sure that there are a number of tools out there that people use. Just work sheets that guides through the sequential evaluation. And I know that, you know, we had one that we used. So at least one DDS does, but I would imagine that quite a few do.

They might be able to -- you know, at a certain point if you wanted to get some examples of

those, I could probably collect them and get them in for you if you would like.

DR. BARROS-BAILEY: And kind of related to that, you had talked about a problem that presents when you have like sit/stand options, and the short fall of the DOT in terms of addressing that. So could you speak to maybe methods that have been developed by different individuals or DDSs in terms of addressing those short falls. I mean, what happens?

MS. LYON-HART: We tend to -- we tend to rely on whatever guidance Social Security gives us. And in terms of, say, the alternate sit/stand, we have sort of rules of thumb, you know, about well, if a person can maintain one position for two hours, and then, you know, when they have a break that they could change, then, that probably would allow that type of work to be done. But if it's more frequent changes that the person has to make maybe -- maybe also positions that they wouldn't normally be working in. Say, the person can only sit for an half hour, then they have to lie down for a half

hour. That might be very difficult to do in certain jobs.

But I think that -- I think that's an area where the policy and the information really needs to be expanded, because that's -- that's an area where we often will get quality return, because we didn't go in the right way. It's easier for two different people to look at the job -- look at the person, the claimant, and the job, and make different decisions.

And part of -- going back to Gunnar's concerns about appeals. One of the things we really want is that if we can have more spelled out policy and better tools, and more definitive information that provides a more consistent -- no matter who operates that tool they come out with the same -- you know, at least, hopefully, they come out with the same set of jobs and transferable jobs, and that kind of thing. To make -- and then use that at all different levels of appeal, even with the ODAR.

So that, you know, administrative law judges -- because -- you know, then your decisions are more consistent at every level. I kind of went

off on a tangent on you, Mary, about the level. I wanted to get that in. I think it's really important that we have -- we use the same tools. I think some of the discrepancies we see now between, say, DDS decision and an ODAR decision are because of the differences in the vocational experts, and how we are able -- you know, the information we have, and the expertise we have is different from what is at ODAR. It would be nice if the whole -- you know, all that expertise was equally there and available, and kind of guided decisions.

DR. BARROS-BAILEY: Thank you. Sylvia.

MS. KARMAN: I just want to quickly confirm that this -- actually, I'm glad you asked the question, Mary; and thank you, Trudy, for responding on it. Because basically, I think this is one of the reasons why Social Security is working on this project, trying to move this forward.

I think the Agency's ability to deliver better guidance or more clear guidance about something such as sit/stand option has a lot to do with the fact that we really don't have that kind of

information about occupations. So clearly, it seems that for the Agency to be able to provide better guidance at any level, we're going to need to have occupational information that can give the Agency the confidence, you know, that the rules its making are going to the issues appropriately. So I think it's just -- that just goes -- the fact that we are unable to deliver that, I think, is really -- speaks to why we're here.

MS. LYON-HART: That's a really good point.

MS. KARMAN: So thank you.

DR. BARROS-BAILEY: Thank you. And I think we have time for one more question. Mark.

DR. WILSON: Thanks. I really appreciate your comments as well. And I would like to echo Shanan, the specificity is very useful. And I think one thing that's coming through loud and clear is this common, more usable vocational analysis tool that takes into account what and how, and the pace of work is very important.

But the other aspect about which you

mentioned is even with the same tool, people don't have comparable training. Could you speak more about that. What would you envision in terms of an examiner training program? What would that need to involve? Where should that take place? And you know, just anymore thoughts of the issue of how we might roll this out. How we might train people, new procedures, would be very helpful.

MS. LYON-HART: Okay. Not being a vocational expert, I don't think I could give you a run down of what the entire curriculum should be.

DR. WILSON: I'm interested from your standpoint, being out there in the trenches, what's going to work, what isn't? What kind of training would fit best?

MS. LYON-HART: Well, I deliberately said in my verbal comments that it should be a training curriculum, as opposed to just training. Because training sounds like, you know, a quick workshop, you know. Social Security -- I don't know if you know -- they have like an interactive video that we can watch training; it's delivered from the nation.

We can watch it in all our offices. Then they have it on video on demand. You can go in -- you can go back and view that training at any time you need to with, say, new staff or staff that was absent the day it was broadcast. That's very useful.

It would be very good -- they have expanded training programs for claimant's representatives, and, you know, basic training, that kind of thing. I think there would be -- there would be a great, great need, and it would be well used to have something like that, that -- I mean, not as long as the entire claims rep training, but a substantial walk through -- first your basic -- all of your vocational -- you know, the whole vocational analysis, how it works. How you use all the tools to get your answers to the various questions at each step.

And then, you know, like I could see a basic training and then the advanced training, and then that -- they can be used by the disability determination how they see fit in terms of if I have a big DDS with a whole bunch of vocational experts,

maybe I only have vocational experts trained in that advanced training, because I know my vocational assessments are going to be done primarily by those people; or the hard ones will be done by those people.

In a small DDS like Vermont where I don't have anybody that does vocational specialist work full time, I probably would have all my adjudicators go through that, so that I can be better assured of accurate decisions; and I think that could be very useful.

Social Security, I have to commend them on their -- they do have vocational training periodically. They're running it more often recently, which is very helpful. I had a staff person attend, and he came back with some wonderful tools, including, you know, a DVD of information. A CD of information in a folder. And, you know, he can then turn around and provide the same training to our staff.

So that's -- that's another method of doing it. My concern is that DDSs may only send one

expert maybe once a year, maybe not even. Maybe they will train their expert once, and then figure that until they get -- you know, that expert leaves and they replace them, they won't send anybody.

You know, I would say that that kind of training needs to be expanded. I mean, it's costly to send people all into Baltimore. If it can be expanded in other venues, and for the broader adjudicative staff at the DDS, that would be great.

DR. BARROS-BAILEY: Thank you. It's 10:15. I would like to thank Trudy, and as I indicated to Georgina as well, but if there is any additional information that NCDDD has, if you would like to contribute to the process, we would be happy to review it.

So thank you both for coming today. This has been very beneficial.

It is 10:15 now. Let's go ahead and take a break. We will come back at 10:30.

I just want to say before we break that one of our Panel members could not be here with us today. She is on the phone, Lynnae Ruttledge. I

just wanted to acknowledge her, and let you know that she is here. Thank you.

MS. LYON-HART: Thank you again.

(Whereupon, a recess was taken.)

DR. BARROS-BAILEY: We're ready to get back on. Thank you.

Again, our presentation this morning is by Dave Schretlen who is a Panel member who will be presenting on the Clinical Inference in the Assessment of Mental Residual Functional Capacity.

DR. SCHRETLEN: Thank you.

As you can see the presentation I like to give this morning appears to be skewed toward the person side of the person job linking bridge. However, I hope that by the end of the presentation people will agree that if Social Security at some point undertakes an evaluation and assessment of the characteristics for successful incumbents and jobs, if at some point we actually look at people who are not disabled, who are doing jobs and assess their characteristics, their residual characteristics, if you will, even though they're not disabled,

physical, mental, emotional, and, you know, whatever, that some of the comments that I'm going to make, some of the discussion this morning really is, I think, germane to that. So I hope you will bear with me.

It may not seem that this talk is directly relevant to some of the concrete tasks ahead of this Panel, but I think that they actually at a deeper level are very germane to both the person and the job side analyses.

So the talk is about -- what I wanted to discuss this morning is methods of inference. How we reason from data to conclusions. There are fundamentally three methods of inference. And they are the pathognomonic sign approach, patterned analysis, and level of performance. There may be others, but I'm not aware of them. As far as I know, this is more or less an exhaustive list.

So there are not a lot of things for us to go over in that sense. But I do want to go over each of them and help you appreciate, help you understand the underlying assumptions and the

limitations, and the threats to the validity of each approach to making inferences. These are inferences about whether or not someone can do a job, someone has some ability that is required to do a job, and inferences about what a job requires.

So let's talk about, first, about pathognomonic sign approach. Pathognomonic signs are in medicine signs that are thought to have high specificity, and they're judged as either present or absent. So when you do a physical examination, you look for -- the physician looks for signs. If the sign is present, it is thought to be strongly suggestive of a disease or an impairment. But not all persons with a disease or an impairment show the signs. That's what it means by -- that's what we mean by high specificity. It might not have high sensitivity, not all people with a condition will show it, but when it's present, it's significant.

And some pathognomonic signs are typically rated as either present or absent, like a pathological reflex. However, there are certain questions that are often ignored, and they are, how

frequently do these kinds of pathognomonic signs occur in healthy individuals? And how reliably can we assess them? How reliably can we determine if someone has one of these signs?

So one study that was very interesting and recorded in the Journal of Neurology a few years back now, involved a -- a study. There were ten physicians, five of whom were neurologists, and five were non-neurologist. They were doing a neurologic examination of ten individuals. They were looking for a specific pathognomonic sign called the Babinski sign. The Babinski sign is what's called a pathological reflex. When it's present -- when the pathological reflex is present, it's thought to denote the presence of a lesion in the upper motor neuron track. Somewhere in that track of nerves.

Okay. Now, the way it's elicited, the physician rubs the sole of a person's foot. And you look at the great toe, whether the great toe flexes upward or downward. A downward toe is normal. If it flexes upward it's considered pathological. It's a pathognomonic sign.

They examined -- these ten physicians examined both feet of ten participants. So ten physicians, ten participants, 2 feet each, that's 200-foot exams. Right.

What they did is they had the patient wheeled in -- or the person wheeled in on a gurney. And they were covered with a sheet, except their feet were protruding out from the bottom of the sheet, and the physicians simply rubbed each foot and decided whether they saw this pathognomonic Babinski sign. For the participants nine had an upper motor neuron lesion, of whom eight were unilateral. That is, you should only see the sign in one foot or the other; and one had a bilateral lesion, so you should see in both feet.

Then, of course, they had one person, who was the control, with no upper motor neuron lesion. So you shouldn't see any Babinski sign.

They did the examinations, and here is what they found. They found that in -- in the 100 examinations of a foot in which there should have been an upper motor neuron weakness, they only found

a positive Babinski in 35 of the 100 exams. That's terrible sensitivity. So the person clearly had documented upper motor neuron lesion disease, had the impairment, but the pathognomonic sign was not present.

Conversely, in -- there should have been 100 examinations. One of the doctors forgot to do one of the feet. But in the 100 examinations of a foot in which there should have been no upper motor neuron -- there was no upper motor neuron lesion, there should have been no Babinski, they found 23 positive Babinski signs. The MD thought the person -- and would have made the diagnosis of upper motor neuron lesion of some kind.

So I'm presenting these data to show you, to make the point, that even something that's considered as robust and reliable as a Babinski reflex, and many, many physicians will tell you this is a pathognomonic reflex.

There are others that are called pathognomonic that they don't necessarily think are the so-called frontal relief signs, the snout

reflex, gabriella reflex. There are a number of other reflexes that are sometimes pathognomonic or frontal relief signs that physicians are much more skeptical about. I have heard many, many physicians say the Babinski is one you can bank on. Yet, this study shows very clearly that the Babinski sign is neither sensitive nor specific.

In answer to the question, should it be part of our routine neurological exam? These academic neurologists said no, it shouldn't. Now, let's find out how -- I can tell you, if you go in and you see a neurologist, you are going to get a Babinski exam.

When psychologist talk about pathognomonic signs, they often refer to a drawing test. Everytime I draw a bicycle, or one thing or another, a flower. I draw a clock.

Here is something that is often -- people are often asked to draw. It is a complex design. It is not a memory desk. We just show the person this and just ask them to draw it, just to copy it. Most people begin by drawing the base rectangle, and

then filling in the details, marching around, and so forth.

Now, I use this clinically -- lots of psychologist do. One of the first things I do when I look at a patient's drawing is just to ask, does this look like a normal Rey? It's called a Rey, because it was developed by a neurologist in France Andre Rey. So it's called the Rey Complex Figure. I always look at it and say, is this a normal Rey?

For example, this is a Rey that I got from someone. I looked at it and I thought, this is not a normal Rey copy. This is not a memory test. The person is looking at this, and that's what they drew.

Many people would say, wow, that seems pretty pathognomonic for some kind of visual -- constructional or visual, perceptual processing. However, this Rey was not produced by a patient. This Rey was produced by a participant in a study of normal aging that we did at Johns Hopkins.

We recruited people from the community. We screened them very carefully. People got a

neurological exam, a psychiatric interview, a physical exam. We did laboratory blood tests. We tested them neuropsychologically. We did a brain MRI scan.

These people were at the hospital for an entire day, sometimes even coming back for a fraction of another day. It was a lengthy and detailed examination.

This was produced by a 91 year old women with 14 years of education, in excellent health. I mean, how many 91 year olds, the only medications they're on was that. That is just not very common. Her IQ was 109. She performed normally on other measures. There might be something wrong with her, but we couldn't see it. Her brain imaging looked fine. Her laboratory blood tests were fine. Her neurological exam was normal.

She produced this Rey, and I would point -- and I'm making the point that not all so-called pathognomonic signs are necessarily pathognomonic of something.

On the other hand, here is the Rey for an

68 year old retired engineer who presented clinically with some brain phrenia. That means he was slowed down. When he walked, he walked with a stooped posture, and didn't swing his hands very much. That kind of walk is often characteristic of Parkinson's disease. Although, he didn't have the tremors that you see in Parkinson's disease. We thought, well, he probably had some kind of atypical, that is not typical, Parkinson's disease.

Then he had heart surgery, coronary artery bypass graph. Then he came back 15 months after the first time we saw him. He thought his memory had gotten a little bit worse; but his Parkinson's disease was no worse, this is the Rey he produced. I thought, you know, well, it's possible that this was due to, you know, the coronary artery bypass graph. There is some literature that people show temporary decline. Why don't you come back in another year, and let's see how you are doing.

So then he came back, and this is what he did. When he came back, his wife said that he had developed visual hallucinations, that he was

thrashing in the bed at night, and that his memory had further declined; but that his Parkinson's disease was no worse, and that he was still driving.

And at this point it became quite clear -- and I want you to just notice that the thing is, sometimes pathognomonic signs are pathognomonic. In this case it really was. So there are some limitations and implications.

Are there any pathognomonic signs in clinical neuropsychology? Maybe, I don't know. It is not entirely clear to me. Probably not for specific diseases or conditions. But more importantly, so called pathognomonic signs, which you will often see referenced in medical documentation that is used for purposes of disability determination include references to pathognomonic signs that may be more common in normal, healthy people than is typically thought.

Importantly, reliability of these kinds of signs is rarely assessed. Psychologists, you may or may not know, can be assessed with issues of reliability and validity, how to count things, how

to measure things. Oh, my God, get a life.

But physicians, on the other hand, are often very cavalier about these issues of psychometric properties of signs that are really critical to diagnosis in medicine. So the take-home message of this approach to inference is that if we recommend that Social Security rely on pathognomonic signs of impairment, we should not assume that successful job incumbents are always free of such signs. It may be that many people who are doing quite well on different jobs, if examined, would show signs that are thought to be pathognomonic of disease and limitation and impairment.

Okay. So the second approach is what I'm calling pattern analysis. And pattern analysis refers to a recognizable Gestalt of signs and symptoms in the context of a particular history; in the context of, you know, specified laboratory findings and test results, and so forth. This is the most elaborate approach to clinical inference; but it's best for patients who have typical conditions.

A person who has typical Alzheimer disease presents a sign -- a pattern of results that are often quite characteristic. So if I hear that a 79 year old women is coming in to see me for an exam, and she is healthy physically, she is alert; she hasn't had any vascular -- cerebral vascular disease; she has good sort of -- social graces are well preserved; and the brain imaging shows nothing but some mild atrophy. And the family reports that over the past, you know, six to 12 to 18 months she seems to be showing a very subtle and insidious progression of forgetfulness, and difficulty finding words in conversation; then we give her testing and she shows really significant weakness on tests of memory, but relatively sparing on test of attention and other abilities, that is a -- that is a pattern that is quite recognizable for Alzheimer disease. That's very characteristic. Everything fits.

But when someone has a pre-existing condition and then develops another condition, or you know, they have an atypical presentation, pattern analysis is not always so good. It doesn't

always work so well. There is a lot of support for this approach empirically in the scientific literature, but a lot of it is pieced together from different studies. And the studies often involve kinds of analyses like discriminant function analysis where you use statistical procedures to identify groups of people.

And the one typical example is a simple example, is there is a test called a Mini Mental State exam. That is now the most widely used test in all of medicine. There was a recent article in JAMA about it. It was developed by Mark Folstein, actually, at Johns Hopkins. It is cited more than any other article in the Annals of Medicine. The Mini Mental is a very interesting brief, little test in orientation and memory and naming. It's often used to diagnose dementia.

And a colleague of mine looked at people with two different diseases, Alzheimer disease and Huntington's disease, and compared their patterns of performance. Even though they were equated for overall scores, they showed very different patterns

of performance to get there. And those patterns were really informative with respect to the kind of disease that they have, whether it's dementia due to a cortical disease, as in Alzheimer; or dementia due to a subcortical disease, such as Huntington's.

Now, one of the issues about this is that when we look at patterns we're looking at variability. So sometimes if someone is giving an IQ test, the psychologist might compare their verbal IQ with their performance IQ, or they might compare a person's intelligence with their memory performance. They're looking for patterns. That raises the question, how much variability do people who are normal healthy individuals show.

And so we investigated this using the -- the aging brain imaging and cognition study that was done at Hopkins that I just mentioned a little while ago. So that's a study in which we recruited people from the Baltimore Metropolitan area just using standard random digit dialect. We just dialed numbers at random. It took a lot of phone calls to get people in.

But we got a pretty broadly representative sample. We worked them up, as I mentioned before. And what I did was, then, look at -- after we worked them up, we excluded people with significant health problems, and we looked at the people who were reasonably healthy -- really quite healthy. And we administered a long battery of tests, for which we extracted 32 measures. We put all the measures on the same scale. Because, you know, like IQ scores will be 100, plus or minus 15. Some other scores might be, you know, ten, plus or minus three. So we equated them -- we put them all on the same scale.

And then what we did was we looked at each individual person and we looked at each individual's person's best score, and their worse score, and looked at how much of a discrepancy was there between a person's best and worse abilities. These are normal healthy people. What we found was that these maximum different scores range from one and a half to six standard deviations. That is an incredible amount of variability.

Sixty-five percent of people produced

maximum discrepancy scores that were greater than three standard deviations. Well, what's a standard deviation? A standard deviation is 15 IQ points. That means that for the -- that two-thirds of the people in our sample, their best score was better than their worse score by 45 IQ points, the equivalent on those 32 measures.

So I thought oh, my God, this is such incredible variability. I was sort of -- I was, frankly, quite shocked. I thought there must be something wrong with the data. And so we eliminated each person's single highest and single lowest test scores and looked at the sort of not quite maximum difference, the next to maximum difference, and thinking that maybe these scores were being driven by a couple of outliers that didn't make sense. But, in fact, over a quarter of the people still produced -- maximumness would be "D" -- maximum discrepancy values of three or greater.

So this is a graph that displays in the black bars all of their test scores, and this shows the number of individual who produced maximum

discrepancy in various units of standard deviation. You can see that most people their best and worse scores differed by two and a half to four standard deviations. And there are a few people who were out there in the five and six range.

So pattern analysis in terms of the limitations and implication. The applicability of this approach varies with how typical patients are. Typical patients are pretty easy to recognize. But atypical patients are not. Especially when the patients have multiple problems, and they really do. In fact, what SSA is dealing with all the time are people who have multiple conditions. You have back problems and depression. You have heart disease and diabetes, or all three or four. You may have multiple conditions.

Then the pattern analysis really kind of goes out the window. It just doesn't work very well. Yet, we are going to be asked, gee, what is the pattern of this person's residual ability; and how well do they link to the disease or the impairment they have to interface with what kinds of

jobs they could do.

This approach, looking at patterns, probably mirrors the task of linking specific residual functional capacities to job demands more closely than the other methods of inference that we're going to talk about. But it might be useful to think about linking specific residual functional capacities to job demands using methods that have been used in this sort of pattern analytic approach like the cluster analysis that R.J. Hardy talked about the other day.

He talked about factor analysis. He talked about the idea of trying to look for clusters of job. We might also look for clusters of residual capacity that go together empirically.

So then, finally, level of performance, or deficit measurement, is the third major approach to inference. And this is the approach that is probably more -- used more widely by psychology, but also in many areas of medicine than any other. And you will often hear people -- psychologists talking about deficits, impairments. And the question is

really -- how do I make this slide advance?

Level of performance is often used to detect deficit or impairment. The question is what is an impairment or deficit? Now, Social Security uses the term "impairment" in a unique way. It is not a way that is used in other areas of medicine. In many ways impairment in SSA is equated with a disease. In medicine we talk about disease, and diseases result in impairment. Social Security sometimes uses the term that way as well.

I'm using "impairment" not to refer to a disease, but to refer to a deficit, a loss or an inability to do something that results from a disease, an injury, or a condition.

And how should we think about deficits? Should we think about them in terms of comparing to a -- peers? That's certainly what mental retardation is defined by reference to peers. Right?

You give an IQ test to someone and compare their performance to a normal sample, and you say that this person's IQ is below 70.

Well, what does that mean? It means that that person's IQ is two standard deviations below the mean or lower. That is considered outside the normal range. Most people would say, you know, when you are more than two standard deviations below the mean, that puts you in the lowest two to two and a half percent of the population.

On any measure, whether it's intelligence or memory or physical strength or dexterity; on any measure that is -- that follows a normal distribution, if a person's performance is two standard deviations below the mean, that means that they're performing at worse than 97 to 98 percent of the population.

Okay. When we talk about that, we usually think of that as a deficient ability compared to normal years. In fact, when you get a laboratory blood test, that's often the threshold that is used to decide whether your laboratory blood test findings are abnormal. It's outside the mean plus or minus two standard deviations.

But in many cases, we have to think about

impairment in terms of the individual. If -- if one of the people in this room had an -- was involved in an accident and had a brain injury. Given the fact that you are probably a person of above average intelligence, if you have a serious brain injury, you were rendered comatose; you had a brain contusion; you wake up from your comma; you recover physically, and you are tested a year later, in all likelihood most of your test scores would be within the normal range. But they might be a lot lower than they would have been before you had the accident. So you have experienced a decline. You have experienced an impairment, a deficit that might preclude you from going back to the work you did before, even though your residual capacity is well within the normal range in a normative sense.

So we have to think about that, because these are two different ways of conceptualizing impairment, but they are both important. They're both meaningful ways of thinking about impairment.

So how do we decide when someone's performance on a test of strength or dexterity or

memory or problem solving is deficient? Typically, we use cut points or cut offs, and I want you to sort of join me, if you will, on a little thought experiment, because I want you to -- I want you to think about this.

Suppose we test the IQ's of one million perfectly healthy people. And by "perfectly healthy," I mean we know that they are healthy. We have a word from God that they're healthy. There is nothing wrong with them. They're physically pristine specimens. They are not depressed. They are not anxious. They sleep well. They get good nutrition. They're normal. These are one million normal people. This is a methodics experiment.

Suppose we test them. What would the distribution of their scores look like? People have seen this sort of familiar bell shaped curve. This is called a galcian distribution, or a normal curve, or a bell shaped curve. There are lots of ways that it's -- there are lots of things that it's called. What it refers to, if you were to give a test, an IQ test, or any test, a test of memory, attention,

executive functioning, strength, dexterity, coordination, any test of abilities that is distributed in a galcian fashion and you were to stack up each person's score on top of each other you would get a series of dots that stack up, and the tallest column of dots would be in the very center, and the next tallest column would be on each side of that, and so on.

So the further you get away from the mean or the middle of the distribution, the fewer people do that. So most people the average range on most of such tests is between 90 and 110. That's because 50 percent of the population fall within 90 to 110. This is that two standard deviation below the mean point. That's the second percentile. If it's a test of IQ, a score that is down in this range is the mentally retarded range, because mental retardation is defined by an IQ of less than 70, and a few other criteria.

So if you test all the people in a given place, like a state. If we could test everybody in the state of Maryland, every single person, we would

presumably have a bell shaped curve and about two and a half percent of the population would fall in this range.

Now -- but I have asked you to think about -- to join me on a thought experiment in which these people are perfectly healthy. There aren't mentally retarded people in our sample. There aren't people with significant health problems. So what would the distribution look like? Would it look like this? I don't think so. I mean, that would be extremely unlikely.

Much more likely we would see that the distribution would be shifted up some. Now, I don't know how much it would be shifted up. This is a thought experiment. But it would be shifted up, and if it were shifted up ten points, that's a very big shift. That is two-thirds of a standard deviation.

That means that the average person in our super healthy sample is smarter than 75 percent of the people in the population as a whole. So it's -- it's a big shift. It could be different, but let's suppose for the sake of discussion that that's the

size of the shift.

If we have a 1 million people, and we shifted it up ten points, we would still have almost 5,000 people who scored below 70 on our test. We would still have -- it would still be a small number of people, small fraction of the population that fall in that category. How do we understand those people? These are perfectly healthy people. Presumably, they're all employed.

Is this chance? Are these just healthy, but nonspecifically poor specimens? I don't know. I don't have an answer to the question; but there are certain conclusions that I think we can reasonably draw from this thought experiment. That is, that there must be some people who are in the lowest two percent of the distribution who are actually normal, who are not impaired. They don't have disease. They're okay. They are just very limited in their intellectual abilities, or their memory, or their attention, or their strength, or their dexterity. You plug in whatever it is in the characteristic of interest.

However, in all likelihood, most of those who are in the lowest two percent are impaired. And, in fact, I think the way to think about it is the further you go down the distribution, the higher the probability the person has an impairment that would impede their ability to work. And that the further down they go, the greater the likelihood of that probability. The greater that probability.

So cut off scores are used to help us decide whether performance is abnormal. It's often set at two standard deviations below the mean. That's often where it's set, but not invariably. Lots of people set it at different places. In fact, in the field of psychology there is no consensus about where it should be set.

So when you are reviewing medical evidence in a disability case, and the person says -- and the doctor says this person was impaired on a test, you don't really know, unless you have the actual scores, what -- where the person was in the distribution. For many people that will mean two standard deviations above and below the mean. For

others, it will mean one standard deviation below the mean; which actually is a low average. That's an IQ of 85. One standard deviation below the mean is an IQ of 85. That's below average.

Many, many neuropsychologists will say that if you are scoring more than one deviation below the mean they considered that impaired. They considered that abnormal. Social Security can wind up letting very inconsistent data in the medical records sometimes without even knowing it, unless the data are presented in actual numbers.

So if test scores are normally distributed, cut off between one and two standard deviations below the mean, will include from 2.3 to almost 16 percent of the normal healthy individuals who will be called abnormal depending on where you set the cut point. And that's on any single measure.

What happens if you give multiple measures. In many examinations, a test battery will include several measures of testing, intelligence, of memory, of executive functioning, of, you know,

language ability. When we have multiple measures, the number of normal healthy individuals who produce abnormal scores is bound to increase. It is mathematically -- they're mathematically bound to increase. You will get more abnormal scores.

So using multiple measures really complicates the interpretation of abnormal performance when you have a battery of tests. I'm not just saying neuropsychological tests, but also suppose you do a physical examination where you are looking at reaching, crawling, pinching, pushing, pulling. The probability -- if you have multiple tests, the likelihood of an abnormal finding goes up even if the person has no problem with pushing, pulling, pinching. It is just by chance. Sometimes people do poorly on test by chance.

Now, we can estimate for a battery that includes varying numbers of measures what the likelihood is that a person will produce a couple of abnormal scores, one or two or more. And in fact, some -- Ingraham and Aiken at the National Institutes of Health a few years ago published a

very interesting article in which they said using a mathematical distribution, called the Binomial Distribution, you can predict how many abnormal scores healthy persons will produce on test batteries of various length.

And they said using this probability distribution, the likelihood of obtaining two or more impaired -- I put it in quotes, because these are normal healthy people -- impaired scores based on selected cut off criteria and the number of tests administered are shown here. So if your cut off is one standard deviation below the mean, that's a liberal cut off. That's going to include a lot of normal, healthy people. If you have ten tests, in fact, the probability is about 50 percent that someone is going to have two or more impaired scores.

If you make the cut off more stringent, two standard deviations below the mean -- that's like an IQ of below 70 -- the likelihood that people will produce two or more scores drops dramatically; it is three percent. You are not as likely to have

false/positive errors.

If you increase the battery to 30 measures, if you are testing pushing, pulling, pinching on both sides of the body, you are looking at upper extremities, lower extremities, it is very easy to get the 30 measures. On a psychological test like the California Verbal Learning Test, alone, that's one test. There are 45 or 50 measures. That's one single test, and we give batteries of tests.

So the Binomial Distribution predicts that with a battery that includes 30 measures, even using an extremely conservative cut off of two standard deviations below the mean, there is a one out of six chance that a normal, healthy person will produce a couple of abnormal scores.

Now, the binominal distribution assumes that all the measures are independent, and they are not; and we know that they are not. So there are other ways of looking at this probability.

Last year we published an article, again, using the aging -- brain imaging cognition data, and

we did a series of Monte Carlo simulations in which we looked -- we -- first, we took 327 healthy people. We administered cognitive tests, and put all their scores on a single metric. Everything was measured in inches rather than centimeters or yards. All the test scores were measured in the same units.

We classified "T" scores as one standard deviation, one and a half, or two standard deviation below the mean. Because "T" score distribution has a mean of 50, and a standard deviation of ten. That means a score of 30 is 20 points below the mean or two standard deviations. That's a very stringent cut off for abnormal. This is a liberal cut off.

We also computed what we call the cognitive impairment index, and that's the number of abnormal scores that each person produced. Then we used both unadjusted, and demographically adjusted scores. That is, we looked at raw scores that were transformed; and then we also adjusted them for age and sex, and years of education, and so on. And we estimated how many individuals would produce two or more abnormal scores using three cut offs. That is,

one standard deviation, one and a half, two standard deviations. We based it on the binominal distribution. We based it on Monte Carlo simulation using both the unadjusted and adjusted scores.

For the 25 -- one of the -- we had 25 measures, okay, the Mini Mental, a Grooved Peg Board, Breve (phonetic) Test of Attention, Verbal Fluency; we used a battery of tests. These are the 25 measures that we computed. In fact, this is a sample that's, you know, sort of very average. Their IQ is well in the average range. It's a normal sample.

So here is what we found. These are -- the first column is predicted, and the second column is the observed proportion of people who produced two or more abnormal scores. Using a cut off of 40 -- that's one standard deviation, a cut off of one and a half, and a cut off of two standard deviations. When you have 25 measures in the battery, what is the likelihood if you use an extremely conservative cut off -- what is the likelihood that people will produce two or more

abnormal scores?

Well, in our assessment, it's about 11 percent; and 11 -- and then these are the demographically adjusted scores. And so whether you use raw score or you demographically adjust, you still get the same kind of story. The story is that the more stringent the cut off, the fewer normal, healthy people produce abnormal scores. But even if you use very stringent cut off, a lot of normal people will score in the abnormal range.

Okay. So then we said, well, let's look at the number of abnormal scores that each individual person produced, and see what accounts for that. Is that just occurring by chance? What we found was no, it is not occurring by chance.

In fact, the correlation between -- the correlation between how many abnormal scores they produce and various characteristics are shown in this table. You can see that there is a very strong relationship, older people tend to produce more abnormal scores. Likewise, people whose premorbid or estimated intelligence produce more abnormal

scores. There were also relationships with other demographic characteristics, but these were clearly the strongest.

So this study shows that neurologically normal adults produce abnormal scores. There is pretty much incontrovertible evidence. We published this. Now, many people, even in the last year or two, have published other findings supporting this. It's not due purely to chance. How likely it is that people will produce abnormal scores varies systematically its demographic characteristics? If you adjust to the characteristics, you eliminate that relationship, but you don't eliminate the fact that they produce abnormal scores.

So these findings underscore the distinction between an abnormal test performance and impaired functioning. Just because someone produces an abnormal finding on an exam doesn't mean they're impaired. It might -- the more they produce, the greater the likelihood that they're impaired.

But I think sometimes there is this sort of almost reflux of notion. We did an exam, there

is some abnormal scores; therefore, the person cannot do this kind of job. That's an empirical question.

Returning to the question of what cut off we should use, stringent cut offs decrease test sensitivity. The more stringently we set the cut off, the fewer people who actually have an illness will be captured by it. We will miss them. We don't want to do that.

But if we use more liberal cut offs, we decrease specificity. The more liberally we set the cut off, the greater the likelihood that people who are not ill will wind up being identified as abnormal. And so -- as in most endeavors, we have to exercise judgment. And it's important -- I wanted to bring this up for SSA, for the Panel; because I think that it's important to appreciate these issues, even if there may not be a clear solution to them.

So -- but remember we also talked about the fact that we might be -- that your performance is within the normal range; but it's a decline from

where you were before you had your -- you know, cardiopulmonary arrest, your TBI, your stroke. And how do we understand that? How do we figure out if someone has an impairment when their performance is in the normal range? That's a real difficult one for SSI to contend with, for clinicians to contend with.

Well, one way is to try and figure out what the person's preaccident, preillness abilities were; and if we do know that, if we know what that is, it's not that hard to figure out whether they have experienced a decline. We can do that. That's something we can manage. But we rarely know it. So we usually have to estimate it. And how do we do that research? And the field of psychology is focused on estimating preaccident or premorbid IQ. And there are a couple of ways of doing that. One is that we know that IQ performance, cognitive performance in general -- not just IQ, but all kinds of performance -- correlate with demographic characteristics, age, education, and so on.

So you can use -- a number of people have

developed equations that predict a person's performance and testing, Barona -- Barona and Chastain did one of the most widely used ones. And they developed a formula to estimate IQ based on the standardization sample; and they found that the error of the estimate was about 12 points.

And so the 95 percent competent interval is twice that. What that means is using this formula -- if the formula estimates that the individual's IQ is 100, you can be 95 percent competent that it's somewhere actually between 76 and 124. Thank you very much. That's not a very accurate kind of estimate. And that's the problem with this approach. It's great for group data, but at the individual level, it's horrible.

And also -- so the next is people have used word reading tests, and they're considerably more accurate, but there are very important caveats. They don't always work for people with limited education; certainly not for people who use English as a second language, aphasia, reading disorders. There are lots of caveats, but it actually turns out

to be a pretty darn good way to estimate premorbid ability.

Word reading tests work this way. You have people read a list of words that increase in complexity and are irregularly spelled. Words like debt, D-E-B-T; or aisle, A-I-S-L-E. These are words you cannot sound out, so you have to know them. You just have the person read them aloud. You don't have to define them. You don't have to give a definition. You just to have to be able to read them out loud.

It turns out that vocabulary correlates very, very highly with overall intellectual functioning or GB. And that word reading ability is really not very affected by brain disease or brain injury in most cases. And so you put those two things together and ability that is really pretty robust, unaffected by disease with something that correlates well with intelligence, and that's a way to estimate a person's premorbid functioning.

And the test -- the test we used in that study is the national adult reading test. It's a

test of word reading ability, and we gave it to our participants at baseline. Then 110 of them came back in at five years later, and we gave them the same test. That's how their performance correlated. That's pretty amazing. I mean, in behavioral science, you don't usually see correlations like that. This test is extraordinary reliable.

You can -- the reliability does not impose limits on validity. The validity is not quite as good, but it is pretty darn good. Here is the scatter plot showing the relationship between the NART estimated IQ, and the actual IQ performance on a test -- on the Wechsler scale done at the same time. You can see that the correlation is not as tight as the other one -- that one; but it's still pretty good.

So the question is how well does performance on this test predict cognitive abilities other than IQ? Because a lot of times what we're looking at after an injury is that a person shows impairment or retention, or memory, or something like that. So the question is whether or not word

reading will predict that. So we compare a person's word reading to their performance on cognitive domains other than intelligence.

And I don't expect you to be able to read this slide; but I just wanted to show you that the correlation between the NART and IQ is really high, as it should be, as it is in lots of studies. However, the correlation between the NART Word Reading Test, and other neuropsychological abilities all significantly lower. Every single one of these was significantly lower than IQ. So we can estimate premorbid IQ, but it's not -- we're not as good at estimating abilities in other domains.

So SSA -- clinicians have to estimate premorbid abilities. When you see a patient -- when a patient walks into your office, you have to make assumptions about what they were like before the accident. Whether they were average, above average, below average, stronger than most people, weaker or less dextrous than most people, whatever. You make some assumptions, judging them by their history, what you know about them.

So my argument is that if you don't do it explicitly, then you do it implicitly. Because even if you say, no, I'm not making any assumptions, well the assumption -- that assumption is that the person mirrors the population as a whole. So if you say, I'm not assuming this person is smarter or less smart. Well, then, the assumption you are making is that they're not smarter or less smarter; it is that they're, in fact, average.

So either you do it explicitly, or you do it implicitly; but even the best method yields just ballpark estimates. We're better at getting estimated premorbid IQ than other ability. So that raises the question of well, then how well does IQ predict performance in these other areas if we know what a person's actual IQ is? And we compared people with below level IQ, range of 83; average IQ with a mean of 101; and above average IQ. In fact their IQ was really superior. That's above the 92 percentile. So that's in the superior range, 120 and higher.

Here is what they did on other

neuropsychological measures, like the Grooved Peg Board and the Trial Making Test, and all these other tests of memory and language, and so forth. The average -- people on average are exactly where you expect them to be. The people with below average intelligence on these other cognitive measures are generally in the sort of low end of average to low average range.

Look at the people whose IQs were in the vicinity of 120. These are extremely smart people. In fact, we had one person with an IQ of 151. It's a very high IQ group. Yet, their is average scores in these other domains that are ranging from like 102 to 108 on average. So I think sometimes we have the idea if a person is really smart that they will do well in all other areas.

The fact is, that's not the case. People who are really smart are often just average in these other areas. So correlation between intelligence and other cognitive abilities are stronger below than above average -- above IQ scores of 110.

The take-home message is that it is less

likely that smart people will do well on other tests than it is that dull people will do poorly. It's important to appreciate if someone is coming in, and they're a person of below average ability to begin with. You are much more likely to find out in normal scores, even if they are perfectly normal, you know, they are constitutional. Their innate endowment is more limited.

So there are some real important limitations and implications of this approach. First of all, there is no one to one relationship between performance and ability. We infer ability from performance. Those can become uncoupled. It can be uncoupled by lots of factors, including poor effort, someone doesn't want to do well. If you give someone a test of visual memory and they shut their eyes or they're blind, they are going to do poorly on it. It has nothing to with their memory, per se.

Adding tests can increase false positive rates, and setting more stringent cut offs can increase misses. And word reading tests predict

premorbid IQ better than other abilities. And raising cut-off scores for people of above average IQ can compound the problems. So these are all some of the important limitations that we gather from this, that characterize this approach to inference.

With respect to Social Security, it's important to keep in mind that many, if not most, successful job incumbents likely fall short of meeting one or more job demands to the extent -- in the same way we can assess memory, attention, and concentration, and strength and dexterity, you can think about job demands as a test of sorts.

To the extent that job demands are a test and that people do them to varying degrees, certain of the people I work with meet their job requirements to varying degrees. Sometimes people are really good to markedly exceed my expectations, others meet them, and there are some who are really not.

So in all likelihood, there are lots of people who are incumbents who fall short of meeting one or more demands. And what cut off to the

distribution of an ability shown by successful job incumbents should we used to define sufficient RFC for someone to do that job? That's, in my mind, an incredibly important and difficult issue that we need to -- and that SSA needs to grapple with, because it will directly affect the percentage of applicants who are found disabled.

If we say that in order to do a job someone has to be able to perform it at an average level, like someone who is average at that job, in the middle 50 percent of the population, if this applicant needs to be able to do a plumbing job as well as the middle 50 percent of plumbers, that's a much more stringent criteria, and there is a much higher likelihood that the person will be found disabled than if we say, "this person needs to be able to perform at the level of below tenth percentile of plumbers." If you can perform at the lowest tenth percentile you are doing it as well or better than one out of ten plumbers. Obviously, that will dramatically affect how many applicants get identified as disabled.

And factors other than impairment, like effort, can uncouple the linkage between performance and ability. This is another sort of concurrent theme that, you know, threads through this sort of consideration of assessment.

Then finally, just to comment on this notice of work demands and residual functional capacity, and deficit versus impairment. Some people differentiate between impairment and deficit in the sense that some people will think of an impairment as any decline relative to your own pre-accident ability, or, you know, any loss of ability due a disease or condition -- that's an impairment -- even if you are within the normal range.

Others have talked about the notion of deficit as a more absolute threshold, can you do something? A deficit, you know, means that you can -- if you have it, then you are not able to do that thing. It's a raw score. So impairments will often adjust.

When we think about impairments we will

take a person's age and education into consideration. This person is performing below what they should be, given who they probably -- what they were probably like before the accident. In a deficit measurement approach, it has been argued that you shouldn't take age into consideration. And here is a perfect example.

This person's processing speed is above average. They are the 75th percentile. And we decide that for an airline pilot you need to have perform -- your processing speed should be at the 75 percentile of the population, better than average; okay.

Now, processing speed is exquisitely sensitive to age in normal healthy people. One of the problems of getting older, when you get to be my age, you can feel it. My speed of processing is not what it was when I was 20 or 25 years old. But probably compared to other people in their 50's, I'm holding my own.

However, the question is a person who is 95 years old might be at the 75th percentile

relative to other 95 year olds on a processing speed, but you won't want them piloting the airplane because the distribution of scores in that 95 year old is so much slower.

In fact, in our normal aging study, processing speed between the ages of 20 and 85 drops two standard deviations. The average 85 year old is at the second percentile of the average -- of average 25 year olds. Now, that's disturbing news I know. We're going there. We're going there.

So if you extrapolate out to 95, it's a -- processing speed is exquisitely age sensitive. So in some cases the take-home message is whether we consider things like age, and education, and other characteristics when we evaluate someone is critically important. And it may be very important with respect the issue of transferability of skills. And it may be that we want to use absolute criteria rather than taking the -- rather than adjusting scores for age or education, something like that when we evaluate strength and dexterity and memory, and so forth. So that's it.

Couple of pictures from Baltimore, and Johns Hopkins. I don't know if people have never been to Hopkins. In the old cortical they have this lovely statute. This is right through that door. This is the old front entrance to the hospital. Here are some scenes from the Inner Harbor. Thank you.

DR. BARROS-BAILEY: Thanks, Dave. We're at a little after 11:30. We might have time for a question or two if anybody wants to ask a question from the Panel. Gunnar.

DR. ANDERSSON: For some physical and organ performance level we do have fairly solid age-related data. So how would you incorporate that in your design?

DR. SCHRETLEN: That's a really good question. The point is we have good solid age-related data for many human characteristics, physical. We also have them for lots of cognitive abilities. It's a really important question, because in some cases it's incredibly important to understand how a person is performing compared to

age peers.

But for other matters -- like, for instance, it's very important to understand how a person is performing relative to others of the same age and maybe educational background and sex if you are trying to diagnoses the presence of a disease. That affects that ability. That strength or whatever.

It's important to know how this person compares to other -- like if you are going to have -- if you want to test strength in someone who is 75 years old, it's important to compare to other 75 year olds, not other 45 year olds, obviously, if the question is whether or not they have suffered some loss of strength due to disease. Do they have a disease that has affected their ability and their strength?

But for other matters it may not matter what their age is. If the question is, can they do this job? Can they lift this bag of cement? It doesn't matter if they're stronger than the average 95 year old. They shouldn't be lifting that bag of

cement. They can't do it safely. So the question is, how should we use age languor data? It depends on the purpose that we are putting the measurement too.

DR. BARROS-BAILEY: Bob.

DR. FRASER: Just a point. We tested -- we tested about 78 individuals with MS coming into our vocational rehabilitation program. And, you know, in terms of, say, verbal IQ, they're above average. Let's say approximately 110. Although, they may have loss some ground due to reasoning. But their memory measures were about 90, 92, you know.

A neuropsychologist might say, well, that's within an average range. In fact, it's within a low average range. But for example, five of these people were nurses. You got a network administrator. In this case even average ain't good enough, you know. So that's kind of an issue.

You send them off for psychological testing, and the experts looking at it goes, oh, those are average measures. The other thing you

have to remember, as a nurse on a ward if you are in a low to average range of memory functioning, that is just not good.

DR. SCHRETLEN: Absolutely. In fact, that is critically important. And I think it's an argument for the importance of looking at successful job incumbents. We don't really know. It's an empirical question. How much strength, you know; how much dexterity; crawling, lifting, pushing, pulling; attending, remembering, comprehending. You know, all these characteristics that we think are important we need to -- in my opinion, we need to look at the distribution of people who are actually doing the jobs to see, because we don't really know. It might be that at 92 is utterly inadequate for that job, but it might not be. We just don't know.

It might be that the combination, having a memory score of 92 and depression is what makes it impossible for the person to do. Because it might be that there are some people who do that job who have scores in the memory of whatever it is, 92, and they're able to do the job, but they're pain free.

And that is the ones who have -- but there is no one who has the 92 and has, you know, weakness -- you know, motor weakness, or you know, optic retinopathy.

DR. BARROS-BAILEY: Okay. Thank you, Dave, for the presentation.

We are now at 1:15. We have lunch scheduled until 1:00 o'clock, and we will see you all back at 1:00 o'clock. We will start promptly at that time. Thank you.

(Whereupon, a lunch recess was taken and the proceedings subsequently reconvened.)

DR. BARROS-BAILEY: Okay. So back on the record now.

As an introduction to our discussion, I would like to review the chronological timeline that is behind the road map in our three ring binders. It is the colored form. If you are on the executive subcommittee, you can see it too.

I mentioned this morning that one of the helpful things with the road map was that it helps us organize our work a little better. And so in

terms of trying to, at least through this fiscal year, add some structure to what we're doing, we put together kind of a timeline of our activities over the next few months.

Has everybody had a chance to take a look at that form?

Okay. And I know that there might be some changes to it as we go along in terms of the subcommittee reports. As people go along, you might talk about that. As you see in the timeline at this point we have a telephone conference scheduled for July 14th, and then we will also talk about August 20th. We have -- not on this timeline, but on the executive committee timeline -- a deliverable in terms of the recommendations for the subcommittees for the 31st of August.

We're thinking of maybe flipping the date of August 20th and August 31st to see if we need to at that point move to have the reports from the subcommittee -- final reports on August 20th for a telephone conference on August 31st vote by the Panel. So maybe at this point we will talk about

that a little bit, and have a little bit of discussion. So that's what we were looking like we might want to consider.

I will open it up for discussion in terms of any thoughts on that process. Would anybody like to --

MS. KARMAN: Yes, I just want to clarify, Mary, that what we're looking for, then, is a draft from each of the subcommittees by that date, so that we would have an opportunity, as a Panel, to deliberate on what our final recommendations are going to be. So that would be the draft from each of the subcommittees, not the whole overall report written by that point?

DR. BARROS-BAILEY: Correct. So August 20th would be the draft in terms of the recommendations. For the subcommittees we're going to have some preliminaries today, and as we go through the process over the next couple of months, refining those recommendations, having a draft of those recommendations coming to us on August 20th, so that August 31st we can meet as a Panel by

telephone conference and hopefully vote on some of the -- those recommendations.

DR. SCHRETLEN: You know, I just don't know what we can say. I will definitely meet the timeline, but I definitely would prefer the three months.

DR. BARROS-BAILEY: We appreciate that, David.

Okay. Then what I will do is ask Debra to make sure -- in terms of the dates, make sure that they're clear for the Panel; and we will modify this timeline as we go through that process.

Then, we have the last Panel face-to-face meeting set for the year on September 15th through the 18th. I know that the place might not be Denver. It says Denver on there, and that's being worked out at this time.

So this is the timeline that -- for the whole Panel that I hope is helpful. As I said, it will change over time. You will get updates as we go through the process. At least it helps put some markers on our calendar as we go through.

So there are a couple of other things that I would like to draw your attention to. One of them was the letter. You should all have a copy of it. It's dated May 26th, and it's a -- kind of a status letter that went to Deputy Commissioner David Rust in terms of our activities to date. So just kind of an interim report to allow Social Security to know what we have been doing until the end of May.

Are there any questions at this point in terms of either the timeline or the letter? Okay. So at this point I would like to have our first report by the Chair of the User Needs and Relation Subcommittee. Sylvia.

MS. KARMAN: Thank you.

Our subcommittee, User Needs and Relations Subcommittee, met yesterday, met earlier this month as well. And some of the things that I just wanted to cover of what our main goals of the subcommittee are, so that people in the audience can know a little about what the Panel had intended for that subcommittee.

What we're focused on really is the

outreach. That will be for informing us about the content of the information -- Occupational Information System. And so -- as well as putting information out into the -- among our users, both internally within SSA, and externally. So it's about that kind of outreach where we are both getting information out about what the Panel is working on, the budget is involving, back to those things, as well as obtaining information that's relevant for, you know, all the subcommittees and the Panel's work on projects as well.

Also, accountability, so that the Panel is able to help Social Security as we move forward with our project. To be accountable to the users. To be accountable to those who are interested in what the Agency is taking on. And also transparency, so that it is possible for others to see exactly what we're working on, where we're going; and as best as we can articulate that, make that clear to people.

So what we have discussed is some strategies around -- to accomplish those things. And one of the larger strategies -- one of the

bigger efforts that we have going on right now that we have begun is Social Security's Occupational Information Development team that is in the Office of Program Development and Research. That's the team that I am leading.

We are working with our internal Social Security work group as well to conduct user needs analyses throughout the entire research and development of the project. So in other words, as the Agency and the Panel is turning its attention to the content model right now, or you know, as we move on, perhaps, the instruments, we will be conducting user need analyses in the form of either, you know, interviews, focus groups, surveys, whatever method seems to be the most useful or most effective for -- given whatever point in the process we're working on.

So right now since we're turning our attention to content model, we have been out developing a method that has the staff actually interviewing and conducting focus groups with adjudicators, both the DDS and at the ODAR level, at

the hearings level.

We're also going to be -- we also involve reviewers, program staff. So the number of people in different position types throughout Social Security who are the prime users, people have an interest in.

We have conducted those reviews starting in Atlanta. At our last meeting we sent staff to work with the Center for Disability, in the Regional Office in Atlanta, as well as the quality -- Office of Quality Performance Group there. And we have the results of that. The highlights of that are in your binder.

So you know, we got some pretty good results from that. Also learned a little bit about how we might want to conduct those kind of things; and we made some changes.

I just spoke with some of the folks who went over this morning to the Chicago Regional Office, and we thanked the Chicago Regional Office very much for their very prompt and -- you know, very helpful outreach for us to help us get this

done on such short notice.

And so what we understand, that the interviews and the focus groups went really well this morning, and we were able to obtain a lot of really good information. So what will be incumbent, then, upon your subcommittee is to provide that information to these other subcommittees. Funnel the information, for example, with regard to mental demands to David and his subcommittee. And of course, the physical issues to Debra Lechner. So anything else that we can infer from the outcomes that we think other people need to see; and of course, we will be preparing a report for that.

So that's one effort that we have underway, and that is really part of a larger effort of how do we stay in touch with what users are concerned about? Who are our users? You know. Right now we're defining them as, you know, the different positions I have just mentioned within Social Security. There are also individuals external to Social Security who are involved in our process. Some of who are very interested in our

outcomes, because they affect -- affect them as well. So we have a wide range of users, and our workgroup is looking at how to get our messages out to these individuals and how to get their information that they have to give us.

And some of the ways that we have talked about doing that is, you know, having periodic updates through the OIDAP e-mail process. We have a list serve that goes out and people can sign up for that. And also posting information that has been vetted within the Agency and has been given to the Panel, putting that on our web site externally, so that people are just simply aware of what's going on. You don't literally, physically need to show up at a meeting to understand what's happening, or at least to have a snap shot of what's going on.

And also to produce, I think, fact sheets, other types of documentation that the Panel members can be using, staff can be using when people send in questions. That other people within Social Security might want to use. You know, so there is another method that we're thinking might be useful.

Perhaps, having not only fact sheets, but, perhaps, Power Point presentations or Power Point slides available, so that when Panel members are asked to speak at whatever professional conferences that they have the material already in front of them that they can pull up. And if they have questions about it or they think something, you know, needs to look different, they can give us a call or we can discuss it whatever.

That kind of helps all of us to know -- to have a little more comfort around what do we do when we represent ourselves or ourselves as Panel members in a public setting. I have already received several questions from some of the Panel members about this, so we thought maybe we would bring this up that in terms of our representation publicly that, you know, as long as we are, of course, stating -- you know, when we are presenting as Panel members that we first check with the chair -- in this case it's the interim chair; and you know, discuss that.

And then at the presentation itself that

we're making it clear that -- when we are, in fact, speaking as Panel members and when we are not. That we are simply wearing the -- whatever hat of our own profession. That sometimes gets into the detail. I think that's really where some of the questions have come from that I have received. I don't know about Mary. You know, people know that, you know, as a Panel member they're going to stick to the facts, and whatever information has already ben made public. So you know, it's not so much -- the facts and the issues about well, you know, we know they're these subcommittees, and they're focused on these issues, you know, that's all factual.

The question comes up as to what happens when, after presenting all that, you get a lot of questions. And the thing of it is well, you know, when you say, you know, these are interesting points and things that -- you know, that might be of value to the committee or to the Panel as a part of the committee, you know, you can suggest that, perhaps, they submit their questions to the committee or to the Panel.

If you -- you could also say that, in fact, it has been on the record. We have deliberated about it. You can say, well, that has been discussed. We are not finished deliberating. No decision yet. Things like that.

So I think that as long as people are clear when we're speaking as Panel members, and when we're speaking as not Panel members that's helpful. And the other thing we were thinking is that maybe if the other Panel members feel that this is valuable, we could also serve as a clearing house for information that comes in to the Panel. And when things are requested or information is requested, you know, perhaps we can, you know, find a way to deal with that. That becomes something for which we might need a process. We will, you know, work with you all on that.

So really you just need to let us know, kind of. I think that's where we were kind of yesterday, thinking about making sure we understand what everybody's needs are on the Panel as well as what the user's needs are. And as we move along,

try to set up the kind of strategies or process that, you know, is the least onerous that would help people on the Panel, help the Panel members as well as make sure the users feel like they can really -- are being heard.

And also, I think we talked a little bit about, you know -- I have talked about the guidance. Let's see. Oh, we came up with some questions that we thought we would ask the Panel about. And one of them has to do with, you know, are there user needs or information from the users that you think you would really -- that you think you are going to be needing. Not just for this recommendation coming up, but as you look forward, if there is information that you can solicit, or that my team back in Social Security could develop a way to survey people, for example.

You know, on our mental subcommittee, David, yesterday we were talking about possibly surveying individuals with regard to the mental demand dimensions -- or the mental dimensions for the person side. You know, so there are maybe some

needs that are coming up within the subcommittees, you know. So if there are types of information that you are looking for, you know, kind of feedback that you want -- I know we're trying to set up, you know, visits at the DDS, visits in ODAR for members. That's, you know, another thing that we will be happy to take care of.

And also, I guess we also want to talk a little bit, I think -- or get your input about how we want to make sure we're channeling or funneling the information that we get. Either through presentations, like the two we had this morning or from our user needs interviews or focus groups, any of the input that we receive from users either externally or internally, you know, I would like to make sure that our subcommittee and my team in Social Security is making that information available in a way that is going to be helpful to you all, and is also something that would help us with our upcoming report.

And -- so, you know, there are ways in which we can -- may want to talk about how do we

want to present that? How do we want to make sure that we have covered everyone's suggestions to us?

I mean, one of the things we do, you know, is -- back on our team is we make a list of, you know, all the action items. All the things that people have asked for. All the things that people have mentioned. And then indicate, you know, what the status is of that. You know what have we done with that? How do we resolve it? You know, do we want that to be reflected that way in the paper that we are going to produce.

You know, is subcommittees going to want to address the user concerns that are specific to their topic within, you know, your section? You know, how did you -- how can we help you with that? You know, how did we have -- how are we thinking about doing that?

And also, the other thing we talked about yesterday was the extent to which we are keeping in touch with the professional organizations, such as the two that presented this morning, representatives from those organizations.

A number of us might -- you know, we have got a long list of organizations that we think are going to be interested in what we're doing. It's not an exhaustive list. I'm sure there is always going to be other groups that we will come to learn about, or make sure that we need to include.

But as we are keeping track of who might need to -- who might need information from us or who might be interested in what we're doing, might be useful for us to think in terms of, you know, do we want to talk about -- who might from our Panel -- might want to be attending certain conferences, because they may have a professional link with that particular organization. And you know, it may make sense for us to have some conversation as we move along over the next few months about representation at different organizational conferences, and things like that, and how you guys want to handle that. Do you have some ideas about organizations that you know that we may not know about that we might want to make sure we're tapped into?

So what we need to do really is give you

guys a list of who we have already identified and you can scan that list and then say yeah, you need to add other groups on it or whatever; and oh, by the way, I have a habit of -- you know, I usually go to this particular conference, you know, once a year, twice a year, or whatever. And you know, I would be glad to, you know, reach out to them and have a conversation about -- you know, making sure we're capturing what their concerns are.

So I don't know if you guys have some thoughts for us or anything. I don't know the -- if the other subcommittee members might want to offer some input.

MS. SHOR: I think Sylvia has done a terrific job of summarizing this. And I do think, Sylvia, probably what would help spark some ideas with Panel members if you get the list out of organizations that we have identified, then you can be thinking about what's missing and just add that.

DR. BARROS-BAILEY: And I think it's also helpful to me to have -- sometimes when I have some concerns about my responsibilities on FACA to touch

base with Debra Tidwell-Peters as a resource for identifying that. So if we run into some areas as people are asking us for information to do things, I think always touching base with Debra is helpful -- always been helpful to me.

Thank you, Sylvia.

Next we're going to have a report from the Physical Demands Subcommittee. Deborah.

MS. LECHNER: Well, I want to just share some preliminary thoughts -- some preliminary thoughts from the Physical Demands Subcommittee, and Dr. Andersson, Dr. Barros-Bailey, and Sylvia Karman and I, have had a few discussions, and we have looked at some literature, and just wanted to share some preliminary thoughts. Just -- and preliminary is the operative word here. Because, you know, it's just things that we have been sort of toying with and thinking about, and haven't reached any strong conclusions one way or the other. So I welcome input and feedback.

What we have done so far is utilize feedback from end users dating back to 2002 when we

did a preliminary reliability and feasibility study, developing a list of physical job demands at the Department of Labor. At that time we went out to the American Physical Therapy Association, IARP, AOTA, and received feedback on the things that they would like to see revised or changed in the current DOT physical demands classification system; and then did a little bit of a reliability study. So we have taken those requests from end users then.

Then, also listening to the different presentations that we have had as part of the panels that we have held so far. Then, just internally had some discussions and considerations of our own. We have started the exercise of developing a taxonomy comparison and Excel spread sheet, quite simply. And that's just in its preliminary stages. So I didn't really feel like we had enough data in that spread sheet -- it's not complete enough to share yet; but we will be sharing that in the future.

In that taxonomy -- physical demands taxonomy comparison, we looked at what I call the little more complete or full taxonomies, like the

DOT, the PAQ, the CMQ. When I mean "full," I mean, they are taxonomies that take into consideration other things besides physical demands.

And then we were also looking at some of the ergonomic taxonomies that have been used and published in the literature that focused primarily on the musculoskeletal system. I will show you some examples of those as we kind of go through this. We're examining that literature. That literature review is in progress.

It seems like everytime I think we have got just about everything, I will turn up another review article and see a lot more information. So I want to show you these things, and then just share with you some very preliminary thoughts that have gone through our heads as we debated this whole issue.

We have identified some categories -- or I think have been referred to as dimensions of physical demands, general categories; manual materials handling, the position tolerance type demands or static postures; mobility movement,

repetitive movement; hand function, balance and coordination. Just giving you some examples on the right-hand side of the slide as to what we will include, or conceptually what we will include in each of those category.

Then general categories of sensory demands, as well as general categories of environmental demands. I won't read them out loud to you.

The other interesting piece of this not only the taxonomy, but what are going to be the parameters of measurement? So for example, the manual materials handling, of course, you would document the amount of force or weight handled; but you have got the size of the object, whether the object has handles or it doesn't; whether it's a bilateral or unilateral activity. Then some things I did leave off that list is the distance over which that weight or force is handled.

Then for postural activities that can be performed while you are doing manual materials handling, or while you are doing other activities.

It's historically been measured in duration in hours, minutes, or percent of day -- as a percent of day. And then there is this whole issue of continuous duration versus intermittent duration throughout the day.

Then there is the issue of frequent repetitions, or frequency, repetitions per unit of time, cycle time. The intensity, how much -- if you are performing stooping, as it's defined in the Dictionary of Occupational Titles, which just means bending over at the waist; how much stooping are you doing? It is just slightly? Is it a much more extreme position?

Some of the ergonomic taxonomies go into a lot of detail about the exact range of motion that's required for a specific position. And then other systems rate it in a general category like normal, moderate, severe; or some of them use the numerical rating systems.

Then there is this whole issue of whether this person is in a balanced positioned, or imbalanced, standing on one leg. Is it symmetrical

or asymmetrical, which affects the severity of the strain on the body. So those are just some of the different parameters we could measure; and you know, the complexity of the system increases exponentially as we get more and more detailed.

So I think the challenge to this committee will be not so much in deciding which physical demands to include in the taxonomy, but what measure they will be measured? And I think that will be the biggest challenge for us here. How detailed do we get?

And something that's occurred to me since the last discussion that we had -- our subcommittee had yesterday that I would like to kind of throw out as a possibility and a way for us to get feedback from some of the end users is that, perhaps, we could propose several different options for parameters of measurement ranging from relatively simple to several levels of complexity; and getting feedback from the end users as to what point, hey, this is -- this is more detailed than we need or is this not enough detail, and so on.

And then, what do we look at, combined postures versus individual joint positions. Our current DOT looks at whole body positions, like squatting or crouching, stooping, standing, and so forth, versus spine flexion, hip flexion, knee flexion, ankle dorsiflexion. So what level of detail do we presume?

I think -- and I will go over this at the end, but I think the subcommittee is certainly leaning more toward whole body positions, rather than detailed joint ankle excursion.

The other thing that comes up in this whole issue of posture, though, is ability to change positions. We have heard that over and over again from the end user that that's a really important issue. So trying to develop some sort of system that quantifies the flexibility of the position, and/or the occupation. How much flexibility is there to get out and change positions. An example of that, may be somebody -- this example has been used, I think, in a couple of discussions we have had. Someone that has to drive for a particular

distance. How long can they drive before they can stop?

If you have a position or a job that requires you to use a computer monitor, using a keyboard, how frequently can you break and -- require breaks and still be a productive worker?

And then for much of the rehab world, the ability to correlate the physical demands of the job with specific tasks is important. That's not really clear. I think the subcommittee is really needing and wanting some feedback, you know, for what are the expectations for any physical demand classification system that you would -- would build.

Do you want to be able to link the physical demands back to individual task descriptions? When we're doing return-to-work rehab, and someone has a lifting restriction, we typically end up trying to help the employers link back that lift restriction to the particular task that required that lifting demand. So I'm not sure that there is that -- there is a similar need for that in the world of Social Security. And so I

think -- but I think that's an important piece to know as you -- and to consider as you develop instruments for making -- for measuring it going forward.

Again, how much detail? The challenge is going to be balancing the level of detail versus the feasibility of data collection.

And then there is this whole issue of things occurring simultaneously, and how much do you break it down. Typically, the head and neck are doing something to visualize the work. The trunk is positioning the body in a position that allows the person to do the work; and then the extremities are contributing in some way to the work. So how do you group things together? How far did -- do you break it down?

With the manual materials handling we have gotten feedback from end users that the things that they are interested in is, is it unilateral versus bilateral on a number of the different activities? Is it combined with trunk -- you know, a nonneutral trunk? And then for pushing and pulling, is it more

of a whole body push and pull, or is it primarily the upper extremities that are pushing and pulling?

And then environmental we have -- we have gone over that a little bit. I think may be a duplicate slide, sorry about that.

And then various -- at various times people have raised this issue, does the job allow for accommodations? Either alternative methods of performing the job, administrative, technical; and do we need -- my question at this point is, do we need to include that?

And then ergonomic occupation systems that we have reviewed. These are just a few that, interestingly enough, a lot of them are easy -- it's easy to get and see the whole instrument via the internet. A lot of them were developed -- you know, I think the question has kind of come up, well, what are other countries doing?

Certainly, this is just in the area of ergonomics; but a lot of these tools were developed in either Finland or the UK. I have highlighted the ones that I am going to show you examples of and

that seem to be most prevalently cited in the literature. Just show you some examples.

The OWAS is the Ovako Working Posture Analysis System. It was developed in Finland, and that really is probably the most cited ergonomic instrument. I know it's hard to see these. I apologize. I did do print screens from the internet from a lot of these to be able to show you. Essentially, they have come up with a numeric rating system. How do I get this to -- a pointer.

So this number is relative to, you know -- this is the back position. This number indicates an arm position, and so on. So you have like -- you come up with this number that sort of captures the whole body position. And you end up with this sheet that describes postures in terms of movement.

And I like the numbering system because it provides a composite score that really describes the -- not only what the position is, but a level of severity. The problem is that I don't think it's very transparent.

So if an employer picks this sheet up or a

DDS worker picks this up, they have got to know, okay, what's a 3222 mean. So I see that there are some advantages and disadvantages of this kind of approach. Do we -- do we want something that's not a verbal description of the position; and so that's -- that's a consideration.

And then another way that they present their data is in this bar graph form indicating, you know, the category one, just the -- sort of the blank category, all the way to the criss cross hash mark indicates the severity of the category. So the higher the number, the higher the hazard in terms of the load that's on the back, the arms, the legs, and so on.

The possible advantage of this kind of system for, you know, documenting hazards is that one could compare like an injured body part to a level of hazard. What I mean by that, let's say you have got a disability applicant who has a back problem. And you could look at different occupations, and maybe most of the time this particular occupation only requires them to be in a

straight back or slightly bent back position. Then if 90 percent of the job is in category one, and it's a back injury, then, that might be an appropriate occupation for that back injured person.

Whereas, another occupation that has 90 percent of the time a category four for the back, that would not be an appropriate position. I am just using those -- throwing out those criteria arbitrarily as an example of how this type of system can be used.

Then there is an instrument called a RULA or Rapid Upper Limb Assessment tool. And this tool I thought -- the neat thing about that, as compared to our current DOT, in our DOT all we have is a verbal description or a written description of the different physical demands. This gives sort of a visual image, so that a person -- anyone could understand what this upper arm movement is all about.

So I like the visual piece of it; and thought, you know, perhaps, we don't need this level of detail in the analysis that we would do; but we

could look at this literature to see, okay, what's the cut point if we're going to define low level, medium, and high level reaching.

What -- in the literature, what's the typical cut point for -- let's see. Like, this is typically what we would refer to as mid-level reaching. And here in this particular system it's defined as 45 to 90 degrees. So could we use some of these things for our definition?

So this fits more into low level reaching, here to here. What we found in our 2002 research that we did, our reliability research -- because we asked analyst to classify low, medium, and high reaching. And it wasn't until we created operational definitions that had some parameters of degrees of shoulder motion that allowed them to have some sort of cut points. They didn't get out goniometers and measure; but they, you know, visually assessed whether it was low, medium, and high. And giving them these angle degrees helped them be reliable among raters.

So this is an example of where -- we may

not have a system that is totally driven by range of motion measures, but we might use the range of motion measures in our operational definitions to help us define certain positions. How much leaning from vertical is required in order for something to be called "stooping"? How much knee flexion do we need in order for something to be called crouching?

These are just some other examples of how RULA uses the pictures to help classify movement. Then they also include a score for force and load, so that they don't just look at position. And there is a component -- that's a different one. There is a component -- even though it is called the upper limit assessment -- the rapid upper limit assessment, there is a component of lower extremity and trunk assessment in it as well.

Then, a very similar instrument, the Rapid Entire Body Assessment. Then what they did is that they developed a composite score that again reflects the intensity of the ergonomic hazard might not be really relevant to the intensity of a hazard. That's not really what SSA is doing; but again,

using the vertical trunk angels to quantify if -- would this be considered stooping or would it be considered standing?

The HAMA, which is the Hand/Arm Movement Analysis, it combines force, position, duration. You know, how long you are staying in the position with the force and the repetition? Its' vaguely this pen and paper system that documents -- the print, I apologize, is very small.

This describes the type of grasp that's going on -- the hand grasp that's going on; and then how long -- how many seconds per minute they're having to hold that position; and then how many movements per minute they are doing.

So if it's a keyboarding activity that this rating system under moving would be a very high, and they would also have a fairly high holding score for risk position as well. So I thought that was kind of an interesting, interesting approach.

Total duration of activity for work day. You know, currently our DOT system divides our work day up into thirds; and this is a class -- they

use -- with their classification system, they break it up into two -- two hours minimum, and then one hour increments there above. And so -- up to the point of, I believe, six hours and above.

So that's one of the inputs we have heard from end users over time is that, gosh, that -- dividing into a third of the day is such -- creates such broad duration categories. So again, looking at this particular study and others that classify work activity as a percent of the work day, what are the other typical classification systems, you know, how are others -- how have others broken out the work day.

You know, I just think the more -- whatever we choose, whatever we come up with, if there are other studies in the literature that have done it in a similar way, I think, lends some support to our decision making process.

They also have a scoring system for covering the variability of work tasks, the flexibility of work task, and the availability of breaks. Again, I can't say this is a perfect rating

system, but it gives us some ideas that we can use to rate jobs according to the variability and flexibility, and variability of breaks.

This was their -- the way they addressed the working conditions. And I thought this was an example of maybe where they had combined too many constructs into one rating system, because they were rating vision and climate, and how the work space was arranged, and the noise and the hand coupling.

It just sort of seem that they threw a big hand basket of stuff in there. And that, you know, if we were -- if SSA were dealing with a client that was visually impaired, these other pieces might not matter so much; but we would want to -- we might want to try to devise some sort of rating system for each of these different pieces.

Then, you know, again, the rating system, I didn't think was all that great for this; but the whole idea of intensity is incorporated into that rating system; and that's just an example of the -- the rating points for the nonneutral positions of the hand and the arm. And then there is this quick

exposure checklist that assesses -- the purpose of it is to really -- was a tool to assess change or improvement in the work setting based on an ergonomic intervention, trying to document before and after improvements.

And the interesting thing I thought about this approach is that they had both the observer's assessment, and the worker's assessment. Some things were self report, while other things were actually the observer's assessment. I thought that was kind of an interesting combination.

And then they had a scoring grid for each area of the body, the back, the shoulders, the wrist, the hand. And this score combined force, duration, repetition, and height specific to the body part. And that was -- this is a rating system that I think combines all of these pieces into one overall sort of severity score, which I thought was a very interesting concept.

So our preliminary thoughts and concerns -- and I welcome my other committee members to jump in and throw their thoughts into this.

Essentially, I think we feel like the DOT has some pretty good physical demand categories; but all the end users that we have talked with so far are wanting additional detail beyond what's in the current DOT. Particularly for these things that we have heard over and over again, reaching, climbing, balancing, upper extremities, specifically as it relates to unilateral, and really to hand grasping too, which I didn't put on the slide; but neck movement, repetition, hand function -- yeah, the hand function, sorry about that. Non-neutral trunk, lateral bending, extension, and rotation, not just forward bending, which is -- which is in the current DOT.

I think the consensus of the subcommittee is that we really don't want to move down to a system where we are documenting joint angles, but that we might want to use joint angles as part of our operational definitions. We understand that Social Security Administration really doesn't need to identify the hazards -- or a hazard level of the job, but there are pieces from those systems that

might be helpful to us as we develop our classification system.

And then, you know, for example, if we're going to say that something is repetitive, what is going to be our operation -- what is our operational definition from that? And I think there is some -- there are some guidelines that we could use or sub on, even though there is some controversy in the literature about this.

We might -- the literature would help us, I think, define our cut points or our criteria for high reaching, and develop some more discrete categories for duration.

Our next steps are finish the literature review and complete the physical taxonomy comparison spread sheet. And we're going to do that for physical, sensory, environmental. And then make taxonomy recommendations for not only the categories and demands, but some measurement strategies; and then get that paper done by August 20th.

So that's all I have. I would like to open it up to questions or comments.

DR. BARROS-BAILEY: I had a question. I think this is for Social Security in terms of the one comment about hazards. If that might be something we can get clarified, particularly, in those jobs where we might be dealing with individuals who have mental/cognitive issues; and where identifying hazards on the job might be important in terms of somebody's ability to carry out a job. I'm thinking about somebody who might be working in a warehouse and might need to be aware of the hazard of being run over by a forklift, that kind of thing. So we might want to explore that a little bit more.

MS. KARMAN: I think that's certainly something that we would want to take back, and you know, we could go back to our user needs analyses and see to what extent that's come up; and I know we talked some about that, so we will do that.

MS. LECHNER: Yes, when I was doing the presentation, I was really referring to hazard as it pertains to an ergonomic stressor for the musculoskeletal system. But I can -- I have heard

what you are referring to Mary as being referred as to a safety sensitive position. So that if you are working in an environment where there are explosive chemicals or around moving equipment, and you have attention deficit disorder, or you are asked to operate moving equipment around explosives or something like that, that there could be certain identification for those safety sensitive positions, you know.

MS. KARMAN: Yes, I think so. I did misunderstand that, because, you know -- to some extent we do need to be able to identify, you know, what possible issues in particular occupations that if somebody has a sensory problem, they would not be able to, you know, be vigilant for those kinds of circumstances in the job. Or if they have judgment issues, you know, of cognitive, functional issue, you know, would they have a problem with that?

So then the question becomes, what level of detail would be useful for Social Security? So we will work with that.

I did have a couple questions. I'm going

to hold off and let other people ask stuff.

DR. BARROS-BAILEY: Gunnar.

DR. ANDERSSON: Yes, I -- this whole field is a very confusing field. Because most of the -- of the systems that you were talking about were really developed in order to classify jobs by activity. And a lot of them have actually -- have any impact on the risk of you developing musculoskeletal conditions. Further, a lot of them actually measure the effects on the body.

So that's our biggest problem is to -- if you work in a forward leaning posture, there is one or two things that might happen. One is you might not be able to do it, because of your back pain. And the second is that if you do it, you might develop back pain. And for the purpose of occupational titles, we have to make a decision. What it is that we're actually trying to do? And my sense is that what we're actually trying to do is to describe what kind of physical stressors exist in the job without taking into account whether or not those are, in fact, harmful or not harmful, because

that would take us one step further.

Now, we get into a very confusing field, where there is differences in opinions about everything. For example, there is several very highly qualified analyses on the literature, and analyses or whatever that would suggest to you that carpal tunnel syndrome and keyboarding has no relationship; and then there are others who would suggest that they do. So it becomes a very controversial field that I don't think we want to enter into.

The other thing is the precision by which you measure these things, because when OWAS was developed -- and I was involved. I lived in Sweden at that time. And the Sweds were working in developing these kind of things. We didn't have access to modern means of recording. So people were actually standing there recording on paper what was going on. And then, subsequently, over the next ten years there was a development from that to video film. And then there was a development from video film to computer analyses of what actually happens.

And you can go even further. There is exoskeletons that you can attach to people that can give you an actual description of every joint that we want while people are all doing all sorts of jobs. And we used them to look at five -- here in Chicago, I mean, there is a variety of these kind of things. There is fairly accurate biomechanical models that can also tell you what the affect of these different activities are on different parts of the musculoskeletal system.

Again, I think we need to be very careful not to go too far, because I think if we do, first of all, we will become controversial to a large degree; and secondly, I don't know that it's that helpful.

So I would be in favor of trying to make a fairly simplistic description of what it is that we are interested in documenting, which is, I think, what Deborah tried to do on the categories of physical demands.

Once you have done that, then, you can go to the next step and say, how many integrals, how

many classes do we need to describe one or each of these dimensions? And now, we have a reasonable system that you could go out, and you can actually use in the workplace. I realize that then you have a number of other factors that influences into this, which includes the environmental factors in which you are working.

There is really very little evidence to relate these environmental factors to musculoskeletal. There may be some, but there is very little to document it. For example, cold and heat have not generated a lot of very useful data. People have gone the other way in terms of looking at that, and then used psychometrics, and other types of tools to make better assessments of -- Liberty Mutual has been a front runner on that particular front.

But again, it's hard to do and it's not necessarily that well -- that well producible and that valid, as David would say; and so I think we need to be somewhat simplistic in our approach to this. Otherwise, I think we will end up just losing

ourselves in an enormous amount of information; and we're just not consistent, which is very difficult for us to in a short period of time decide what is the best.

DR. BARROS-BAILEY: Mark.

DR. WILSON: I had a similar, I think, kind of related question as Debra was speaking, and I don't know if you are really prepared to answer this yet, but it is -- really is kind of depth versus breadth, and I came up with a couple of different aspects of what you were talking about.

One is sort of a taxonomy -- I'm sorry, what the physical demands are. I came away with a clear indication that needs to be expanded a little bit on some things we need to talk about. Then I thought you made some very important comments about, well, that's not as big an issue as what is it we collect about that. There is a lot of different types of measures and different aspects of measurement with regard to whatever dimensions you come up with.

So any kind of thoughts or guidance you

can give us on the whole depth versus breadth. I think what Gunnar said, should we have fewer dimensions, but just nail them? Or should we have more, but not get excessively into, you know, all the different aspects of it?

MS. LECHNER: My gut answer to that, without having thought it through completely, and without having discussed it with everyone on the committee, which I think is important -- and I welcome you all to chime in too -- but, you know, our current system is based -- all these things are really either documenting the force that's required and/or the duration of -- purely, what percent of the eight hour day is someone doing this?

And the challenges that, I think, clinicians struggle with, as they evaluate disability advocates or whatever, is if you have to do something up to a third of the day -- if you do it intermittently throughout the day, that's one thing. If you have to do it all continuous, then that's really a different demand.

So, you know, the main thing that I hear

from the community and the end users is give us more discrete categories so that we're not looking at a third of the day, not looking at 10 percent of the day, or a quarter of the day intervals. Give us more discrete categories, and maybe that's the only change we make.

You know, it would certainly be an easier transition for the folks that are out there evaluating the people side, you know. If we start to throw in cycle time and number of repetitions and degrees of severity of the position, and we factor all that in, first of all, a lot of these models have been sort of put together; and I haven't reviewed the literature well enough or in depth enough to say are they even validated models, you know. Are they weighted models. Are they just throwing some numbers together and weighing everything the same.

So you know, my gut thing is -- my gut reaction to what would be the easiest and probably the most palatable piece for both sides of the table is just more discrete duration categories; and

perhaps more discrete weight, you know -- because like medium work is from 20 to 50 pounds. That's a huge range. So maybe more discrete weight categories, and more discrete duration categories. And that would be -- to me, that would be the least change that we could make that would be meaningful and welcomed in the community.

The other piece is -- I think can be extremely important when you are looking at work tolerances; but I think Dr. Andersson's point is really well taken. There is just so much; it's controversial. We could probably establish some arbitrary categories and arbitrary rating system, but how valid would that be? And maybe something like that could emerge from research over time. You know, maybe that's a piece that gets built into the evolution of this system. So that's kind of my gut.

DR. BARROS-BAILEY: Gunnar.

DR. ANDERSSON: There is some physical categories that are not included. We talked about some of them before, pushing, pulling, for example, and some other activities. Those are easy to

include.

I think on the fourth measurement slide -- I mean, medium actually is lifting up to 50 pounds occasionally, 25 pounds repetitive. So you do have repetitive in there. It doesn't say what repetitive is, eight times per hour, 50 times per hour. You could, of course, be much more specific about that if you really want to.

The problem of being too specific is that now you create a really, really difficult analysis package. And when you look at this what's practical right now is that if you say, for example, that 50 pounds maximum, 25 pounds repetitive, and I send a patient to a functional capacity evaluation and they determine that they can do that; then, I can send the patient back to a medium level hearing, and it's very easy for me.

If, on the other hand, they say, well, he can only lift 12 times an hour, 25 pounds; and maybe once a week 50 pounds, then it becomes extremely difficult. And now -- so we don't want to make it more difficult unless we can document for sure that

it actually is justifiable, in which case we should make it more difficult; but I don't think we can.

So I would try to do exactly what you're describing. I would identify the areas that are not included. I would add more detail on many of these -- for example, right now there is no detail on sitting and standing. It's usually by hours. So sitting more than four hours or standing more than four hours -- well, that's not a good dimension, because four hours in a row is very different from spread out during work day.

So there are certain elements to each of these that we need to add in order to have a better view, and a better understanding of what are the actual, physical requirements of the job. I think we can do that reasonably easy without making the whole system so complicated that it just won't function.

DR. BARROS-BAILEY: Okay. Mark.

DR. WILSON: That's very useful, and sort of summarize what I heard really as well. Not much more breath, maybe a little more. But definitely

more depth in some areas; but depth that's designed to support the various decisions that need to be made. Then my question is -- I understand not increasing the complexity; I'm very sympathetic to that.

I guess my question is, where do the current cut offs come from? How valid are they? Should we be doing studies that validate whether or not -- you know, granted everyone is comfortable with these decision rules, but do we know much about where they came from, and people are used to them. You know, again, one of these number of reliability validity assess --

DR. ANDERSSON: -- assess --

DR. WILSON: -- psychologists.

DR. ANDERSSON: They were taken out of a hat.

But again, you have to remember what the purpose of these is. If the purpose is to determine safe levels, then, they're not good. But if the purpose is to determine what you are actually able to do, then, they're fine.

MS. LECHNER: I think the purpose of these levels were more along the lines of let's semi-quantify the physical demands, let's quantify the person's abilities using the same categories, so we can match apples to apples and oranges to oranges. It could be -- the cut point can be arbitrary as long as we're using the same system on both sides. We're just saying how much of the day does this person have to do this, and can this person do it for that much of the day? So.

And I, you know, presented the other pieces not to say that I believe that's for the depth we should go to, but more or less to say this is what's out there and to show that we -- and to document as a committee that we didn't ignore that literature; and that we looked at it and decided yay or nay for some practical reasons.

DR. BARROS-BAILEY: Sylvia.

MS. KARMAN: Thanks. I -- two questions, Deborah.

One of them is, you asked for feedback on measures needed from users. And so I think the next

time we meet in our subcommittee, we probably want to talk a little bit about that. I'm going to take that down as an action item, follow-up on that.

The other thing, too, is that as we talk about that, some of that information may be coming out of our focus group. It is also something we build into the focus group testing that we will be doing with whatever prototype instruments we develop. So that maybe we want to show users, you know, different instrument outcomes.

Well, it could be this, or it could be this. And how useful would this be, given our adjudicative experience? You know, we could superimpose that and show it to users and say that -- how does that -- how does this work for you? Or even give them a sample claim, and say, all right, you have got this situation, how would this work, given these measures?

One of the things that comes up, and this is my second -- well, actually, second point after the tasks and correlations. But the other point I wanted to make about the measures issue, which,

again, I guess we're not going to know until we really begin to pull together our content model and develop some instruments and actually get out and start testing them with users, with claims that have been decided, and look at comparisons to see what are the effects -- what are the program effects? What are the adjudicators having trouble with?

One of the things I know we're struggling with, both in the Mental Cognitive Subcommittee and the Physical Subcommittee is what can Social Security obtain -- you know, what kind of information can we get from the claimant in the first place?

You know, so to the extent that we -- I'm really heartened to hear that people are talking about making it more simple as opposed to not more simple, because that is an issue, you know, where we can look at possibly getting measures of job demands down to the, you know, micro ounce or whatever. It just gets to a point of where, yeah, as an adjudicator, how would I ever get the information about the claimant, what they're capable of doing.

You know, that marriage is really important. It may be there is probably really great information you can get about the occupation that Social Security -- as we begin testing our instruments, we may be throwing out some of those items, because Mark was presenting yesterday and saying, you know, we're manned up with a lot of items to start with to test on.

So for example, the physical subcommittee might be recommending, and the mental subcommittee might be recommending a lot -- you know, numbers of dimensions and examples of items underneath that, or elements underneath that, that that might capture. In the long run, we might end up tossing out some of those, because -- yeah, we can measure them really well in the world of work possibly. So that we're satisfied with that. Then the question comes up as to whether or not -- you know, how practical is it? So anyway, that was one thing.

Then, the other thing was the -- the other question I had was on the correlation of physical demands to task. I thought maybe if you get Mark

and Shanan and perhaps give us some insight about that. Because we have been talking a little bit about the extent to which tasks and physical demands and skills sort of intersect. I know we haven't quite defined what level of tasks we are talking about.

We think pretty much that it is not going to be at that level that we are accustomed to in the Dictionary of Occupational Titles, because we would like for things to be so that you can compare obligations across the board. But to what extent can we correlate physical demands with the task, such as we're defining them? We haven't completely defined that yet, and how does that fit in with skills so that that gets identified.

So I don't know, if I'm making sense. If I'm not, just ask me. I will try to clarify.

DR. GIBSON: I will take a rather simplistic answer to probably a much more complex question. It seems to me that the answer is depends. What we would like to do -- and I think Mark has talked about this extensively and very

well, is to minimize the inferential leap that's necessary to be made when one goes from talking about -- we're going to call them meta tasks just for fun -- to the demands that are placed on the person by those meta tasks. So the idea is it will depend on that -- how big the inferential leap is. In order to minimize that, the answer is, it depends on how the items are written.

We're actually -- at some point items will be written to measure those meta tasks as we describe them in both categories, and they can be more or less specific in how they relate to physical demands, or mental cognitive demands. So that will play a huge role. The more tightly they are written, the more naturally they will highly correlate, and a smaller inferential leap will be required.

So at this point it's very hard to say, is it viable? Yes. Can we test it? Not until we have data.

Ideally, that takes us back to the idea of pilot testing. At some point an instrument is

created. We go out, take it and see. We then look at the numbers. That will also be a decision making factor, a determining factor for us probably, because of the items we keep. The items that are most predictive for you will be the items you will want to keep as well.

I know I am pushing data driven empiricism here. I think that's what you will need to see to make that determination.

MS. LECHNER: In the current DOT, there is no correlation between physical demands required and individual tasks. So it's something that isn't present now, and I'm not so sure that it's going to be an issue for the purposes of SSA. But I know that in the rehab world when people are out doing job analysis, they are typically trying to tie back the physical demands to individual tasks, because that's how they help employers translate patient restrictions to what they can actually do back at work. But for your purposes, I'm not sure that it's really relevant.

DR. BARROS-BAILEY: It's 2:30 -- almost

2:30. We have public comment coming at 2:30. So what we will do -- I know we have four public commenters. Then we will have a little bit of time at the end of the hour designated. We will take a break at the end of the hour. I would like to kind of stay on schedule with that. And we're going to have time for deliberation when other subcommittees present. We can take up the task at that point.

In order for the Panel to hear from the community at large, at this point we will go ahead and open the meeting to allow for public comments. I would like to review the guidelines for the commenters.

Each of you will be allowed ten minutes for your comments, followed by Q and A from the Panel members. Today we have four individuals giving public comment. I would like to welcome Beth Alpert. Okay. Welcome.

She is from Beth Alpert and Associates.

MS. ALPERT: I didn't realize I was going to be first. I would like to thank the Panel for the opportunity to address it regarding the --

DR. BARROS-BAILEY: If you could turn your mike on. Just tap the button. Thank you.

MS. ALPERT: I would like to thank the Panel for the opportunity to address it regarding occupational issues and Social Security. I'm not a vocational expert. I'm not a statistician. I'm not an organizational psychologist. So I do understand half of what you are talking about. I do represent claimants before the Social Security Administration, and have been doing so for more than 25 years.

I meet with claimants daily and would like to relate to you some of the real world examples of claimants, and how important these individualized evaluations of the Social Security process is to the claimant, especially the individualized evaluation at step four and five of the sequential evaluation; can a person do their past relevant work? Are there other jobs in the economy this person can perform?

My clients have given me permission to relay some of their case histories to you, probably because they won their -- their cases, and are disabled and on benefits. I would like to relay

just a few of these examples.

Ms. B is a 23 year old woman. She is visually impaired. She came close to meeting the listing for visual impairments, which would have been a per se disability. She did not meet it exactly.

At the hearing, the vocational expert testimony was taken, and the ALJ found Ms. B could not perform her work -- could not perform work requiring bilateral vision, had no vision in the right eye; could not perform work requiring peripheral vision. She had limited visual acuity efficiency. She would need visual protection to avoid hazards in sporting types activities, and she could only read large print. Ms. B is attending college at this time.

The vocational expert was able to take into account the accommodations that the school provided for Ms. B. She must sit in front of a class. She has a note taker. Extra time was given for assignments. Books on tape or large print books were provided for her. She was allowed to leave

class early to avoid crowds. And so the vocational expert took all these accommodations that were given and applied them to the real world setting.

This is something that's hard, I think, to quantify and to put into some kind of list that everyone would -- or residual functional capacity grid like we use for the physical problems. In this case it was good that there was an individualized assessment under the hearing. Because of the vocational expert, this is really a success story. This is how Social Security should work.

She will get her college degree, and while on Social Security she, hopefully, will be trained with skills she can use to sustain a job and get off benefits. But without the vocational testimony she probably would have been denied, because she did not meet the listed impairment, and there would have been no way to take this individualized case and figure out what degree should be used.

Mr. M is a 56 year old man. He has a good work history as an accountant. He suffers from peripheral neuropathy, major depression with

prominent anxiety, and obsessive, compulsive features, and hand tremors. In this case the vocational expert was able to shed light on how the excessive compulsive features required him redoing his work over and over; and, in fact, did so much erasing that he was making holes in the paper, meant that he couldn't perform at a competitive rate. The hand tremors also affected both gross and fine manipulation, and the time it took him to do the activities.

The depression affected him by taking him off task, and also affected his absenteeism. One -- one or two of these problems may or may not have gotten the claimant disability, but the vocational expert was able to take the limitations in total and put it to the real world of work.

Mrs. K is a 45 year old women with breast cancer. She did meet the listing of impairments or would not have been found per se disabled. She was unable to use her dominant arm for repetitive tasks. She could not use the dominant arm for overhead reaching or lifting. Due to the extreme fatigue

from radiation and chemotherapy, she needed many breaks during the day.

Once again, thanks to the testimony of a vocational expert, we were able to get her on benefits before she died, easing her last few months knowing her children were financially being taken care of.

Vocational expert testimony helps address many factors that are found in the real world, pain, problems concentrating, paying attention, staying on task, lack of manual dexterity, absences from work, frequency of breaks, side effects of medication, elevation of legs, loss of use of a dominant or non-dominant arm or hand, inability to reach overhead, inability to perform repetitive motions, a need to change position, and how the job the claimant was doing is performed in the real world, and not necessarily only how it was performed in the dungeon.

Though at first blush it may seem we can easily put all cases in a few simple categories and consider them cookie cutter cases; they are not.

They are often subtle and non-subtle differences with each case, which must be individually analyzed. How does a person's impairment and resulting limitations affect his or her ability to work in the real world? And that's what we're looking at, the real world.

I have found that the vocational experts who work in the real world, evaluating jobs, and helping to place people in the work are in the perfect position to offer opinions as to how a person's ability, limitations affect the ability to sustain employment. While there is the temptation to make a grid-like model using nonexertional limitations, I request that this temptation be seriously considered and resisted; because the nonexertional limitations are much greater than the physical ones. The number of different ones, and the continuing of them; and the interplay between all the limitations.

And that's important is the interplay, because the claimant may have problems with concentration, paying attention, getting along with

a supervisor, co-workers staying on task, completing a work day, work week. And individually, one or two of these elements might not stop a claimant from working; but in combination, they would.

So to say that you meet one or two of these, or three or four doesn't really take into account what's going on in the real world, how they interplay with one another. Because they each have different weights, depending on the job the claimant is doing and what you are looking at.

For example, someone that missed one day a week would not be able to sustain substantial gainful activity. Pretty much most everyone would agree on that. Someone that was off task 50 percent of the time wouldn't be able to. What if this person missed one or two days per month, and was off task five to 15 percent of the time?

Where in that continuum would it be that the -- you know, that they couldn't sustain substantial gainful activity? Once again, I think a vocational expert helps us, because we don't -- it would be impossible or ridiculous to set something

up to say well, if it's 5 percent, then, it should be this percent of that, 5, 3, 2, 1; you get the point.

And it's not whether someone can do a job or get a job, it's whether they can sustain a job. That's where, once again, someone that's working in the real world and the changing of what's going on and expected helps.

And I think we can all agree that there are problems with the DOT. More than a little portion of it is outdated. The jobs no longer exist. They have been fundamentally changed. But I'm not sure why the DOT cannot be updated by Social Security. That it has worked well for a number of years; and I'm not sure why we necessarily have to go to a totally new system.

And I would ask the Panel to consider updating the DOT. It doesn't have to be done at once. It can be done over a period of time. We have waited this long, and it can be eased in. I would suggest that sedentary jobs seem to be in the most need of updating, because of new technology and

globalization, and to focus on that first.

The DOT tends to be user friendly. It offers consistency, uniformity; and for the Dalbert, it is recognized by the courts as being an acceptable measure. Any new system I fear would be open to similar Dalbert challenges; and we would finds ourselves in court for years before it became accepted and outdated.

I would like to give a few more examples --

DR. BARROS-BAILEY: We're sort of right at ten minutes. So if you can be very quick, that would be great. Thank you.

MS. ALPERT: Most cases are a combination of impairments where symptoms wax and wain. And once again, sustaining benefits -- sustaining activity, not just doing it. Also just like to add a caveat about interviewing claimants. I do this everyday; ask the claimant what they did on their job.

What I find is they often underestimate what the requirements of a job were. How much did

you lift? 10 pounds, 20 pounds. What was it? Four gallons of liquid. Well, we know that four or five gallons of liquid -- we know that to be 40 pounds, not ten or 20 pounds. Same thing, how much do you lift? Five pounds, two cases of soda. That's 24 pounds.

So I would suggest that observing these jobs probably is going to be more beneficial finding out what really goes on, than just asking the claimant. Also, claimants tend to say no, there were no accommodations. I did my job just as well as the person next to me.

You talk to the supervisor, you talk to co-workers you find out in fact, they were given less assignments, maybe more time to do the job. Co-workers were assigned to do part of the task. They have been there 20 years, 30 years, and often they don't know the accommodations that have been made to do this.

I would just ask on behalf of claimants that whatever system you come up with offers the claimant a full and fair individualized

determination with the real word, and the combination and interplay of their impairments and weighting them appropriately, and that each case -- or each case is different, and the resulting limitations are different, and they all have to be taken into account. Thank you very much.

DR. BARROS-BAILEY: Thank you. I appreciate your time for coming here. I do want to just say in terms of the vocational experts, I think what we're attempting to do is take it from an abacus to something more modern that can be an applied tool. It will not replace the judgment -- the clinical judgment of vocational experts; and it will, hopefully, help them do their job better.

MS. ALPERT: I appreciate that. I just not like to see their hands tied, because we do find so many subtle differences on the cases, and so many factors that have to be taken into account. Thank you.

DR. BARROS-BAILEY: Thank you. Are there any questions from the Panel?

Thank you for your time.

Okay. Now, we have Mr. Tom Yates. Tom Yates is with Health and Disability Advocates. Welcome.

MR. YATES: Thank you. Thank you -- is this on? I guess it is.

Thank you. I will keep my comments brief. You will have been here all day. I think we're standing between you and a break as well, is that correct?

So I do have my written comments and materials. They're not long. You can read them. I have been an attorney. I work at a nonprofit agency in Chicago. We represent individuals seeking benefits. We also assist individuals with disabilities attempting to work or return to work. So we kind of see it from both sides at our shop.

I have a couple thoughts about redoing the DOT. First, we acknowledge as you do, I think, that it needs to be replaced. It is outdated. We spend a lot of time looking at it, finding interesting job descriptions that we can't imagine anyone can do.

I think my favorite has always been dance

hall hostess, which sounds vaguely a wiggle to me when I read the description; but that is neither here nor there. I think it's agreed that we need to do that.

Our sense is when we look at it, when we look at what's considered to determine whether someone could work, it seems difficult to create a system that would consider every factor that would come into play when you are looking at whether someone can work. I suspect -- I think I'm hearing some of this in discussion today that you are going to try to build an overall system that improves what we have, but leaves room for variation, because so many cases are unique. Some people we see, you know, really don't have an anomaly. They really have so many conditions, or their conditions are so unique.

Second, I think that whatever replaces the DOT has to factor into consideration and still acknowledge in the statute consideration of vocational factors such as age, education, and work experience. I think they have to be considered in

combination. Age in and of itself isn't really that big a factor. I am 50. I heard someone this morning say he was in his 50's, and we're both functioning pretty well, I think.

What I see, though, is people in their 50's, very little education, no real job skills. When they lose their jobs, they're really adrift in this current economy. They are not well equipped to transition to other jobs. They don't have educational skills. They never learned how to use a computer. They don't have much of an education. They don't have skills to help them move somewhere else. I think that has to be considered.

Third, the DOT never really distinguished between part time and full-time work. At least from my angle as an attorney, I realize that once someone has shown they can't do their past relevant work, you need to show that they can't do -- there is not other full-time jobs that exist that they can do. I think you need to focus on the fact there are many jobs that I think in the DOT now that are really performed on a part-time basis. They do not exist

in the economy on a full-time basis; and I think that needs to be thought about as you are updating the DOT.

Fourth -- and there is a long list in my written statement, and I think I just went through a number of them. There are a number of symptoms that -- and other kinds of factors that have to be considered in determining whether someone is able to work or not; pain, fatigue, reaching limitations, manipulative functions, sensory loss, dizziness. And probably one that's most important, mental demands. Whether someone can handle more complex tasks. Whether they can get along with others. Whether they can concentrate adequately to do a job on a sustained basis; not on a sustained full-time basis. That's not in the DOT as it is today. I think that we need to look at them.

Finally, I will close with saying that every case is unique, and the Social Security Act does make that clear. Social Security Regulations say that evaluation of symptoms is unique to each claimant. Different individuals have different

reactions to such symptoms, and you need to investigate that as you are making this decisions. So any system that doesn't factor that in, I think would not be a system that adequately determines whether people can work or not.

Thank you very much. You have a daunting challenge. I will be watching. I'm glad I'm not on the committee, quite frankly; but we will be watching very equally to see what you come up with.

DR. BARROS-BAILEY: Mr. Yates. Thank you.

Tom, you had a question.

MR. HARDY: Just very quickly. You said you thought that some of the occupations in the DOT that are listed are now part-time occupations. Can you give me an example of one or two?

MR. YATES: Sure. Bagger in a supermarket. At least as I see it performed in this metropolitan area, it tends to be a part-time position.

Some time you see greeters -- we don't have them in Walmarts in Chicago, but I visit my relatives. I know when you walk in, there will be

someone greeting you there. I don't think that's a full-time position, for example. They tend to be shorter time.

A lot of loading positions, UPS positions -- now, I know they are done full time, but a lot of jobs are just not hiring as full-time positions.

It is pretty common for me to see individuals who come in -- not necessarily because they are applying for disability, but for other purposes who may only be working 20 hours a week. That's the position they have.

MR. HARDY: Thank you.

DR. BARROS-BAILEY: Thank you, Mr. Yates.

As you pointed out, like Ms. Alpert had pointed out, there isn't -- we can't include every variable in a new OIS or any OIS. I think to emphasize, when we are looking at evaluating people with disabilities it's a very heterogenous population in terms of function so that clinical evaluation of vocational experts remain very important within that process.

MR. YATES: Yes, I think I said in more than one or two, the complexity of the task, which you have.

DR. BARROS-BAILEY: Okay. Gunnar has a question.

DR. ANDERSSON: Fortunately, we don't have to be as concerned as you are about some of the factors for disability determinations since we are trying to classify the job. On the other hand, the things that you are mentioning here clearly are the ones that needs to be included in the classification in order to able to make these determinations. And so it's hard to know how to deal with issues, such as pain, fatigue, and other things from the point of view of classifying jobs. That sort of happens on the other side.

MR. YATES: Yes, and I think part of it is in response -- that you are looking at whether someone can sustain an activity. And at least anecdotally, what I see is that someone may have a condition, say, early multiple sclerosis, or something where they might be able to function for

two or three hours a day; but to expect them to do eight hours is very, very difficult. To expect them to do eight hours day in and day out is very difficult.

When I see some of the different models that are used, for example, in long-term disability claims, I often see that something they missed there is that they really don't have a good way -- I'm not saying it's a problem with the model. It's something that's not in there -- is you don't have a good way to assess whether someone can sustain something over a full time -- you know, full-time position, which is what you end up doing when you get to step five of the sequential evaluation.

DR. BARROS-BAILEY: Okay. Thank you for your time. We appreciate it.

Next, we have Mr. David Traver with Traver and Traver. Welcome.

MR. TRAVER: Thank you.

My name is David Traver. I am an attorney; I am also an author. I brought a present for you. I bought a copy of my Social Security

Disability Advocates handbook for you to use. I am donating that to Social Security Administration for your use. I ask that you please take a close look at chapters 13 through 20.

I am also a vocational professional. I did understand everything that you said today. I have a Master's Degree and a Bachelor's Degree in Vocational Rehabilitation. And I was especially in vocational evaluation. I used to run one of the largest vocational evaluations departments in Wisconsin back in the '80's. So I understand the role and function of vocational analysis and putting people into the world of work, and the relationship between those two.

I wanted to object to what -- to something that I have heard this afternoon. I came in after a nice lunch and sat down, and heard you talking about end users.

I think Attorney Beth Alpert gave really good examples of who your end users really are. Your end users are the tens and thousands and millions of disabled and disadvantaged people who

come to the Social Security Administration. When they come to the Social Security Administration, they need help. They need help because they're losing their homes, because they don't have health care. They want to work, but they can't work.

These are people, in the majority, who have -- are filing a Social Security Disability Insurance claim. They paid, just like you have for all of these years out of your FICA to buy a disability insurance policy.

And any one of us -- we are all here because we're working today, we love to work. But any one of us could become disabled tomorrow. We can have a slip and fall in our bathrooms, hit our heads, and suddenly find ourselves with a retractable case of epilepsy. We might be type one diabetic, like the Supreme Court nominee, who is type one diabetic, and suddenly over a period of time finds herself unable to work, because she can't control her A-1-C anymore. Those are the people we serve. Those are the end users.

I want to show you with a scientific

experiment about how your data that you are going to put together -- and God willing you do a wonderful job with it. I want to show you how it's going to be used at hearings at the Social Security Administration. It is something that's done tens and thousands of times a year. It's happening right now, as we're sitting here today somebody is being asked -- a vocational expert is being asked a question like this, and here is the question.

Assume a person is age 47 to 52. That person will be limited to light work with a sit/stand option, limited use of his right hand and arm. No fine manipulation with the right hand. No over head work with the right hand. No lifting and carrying objects weighing over two pounds of weight, and with the sit/stand option.

Now, to that, add this question, how many jobs -- rather you have 15 seconds to answer this question, because that's how long they usually give a vocational expert to answer a question like this. What are the jobs that the person is eligible to do, and how many of these jobs exist in the present

economy in Chicago and nationally. And think of the answers. And if you would like me to repeat the hypothetical, I will. And I'm going to guess that your time is about up.

Now, when I was going to do this originally, I was going to have you write the answers on a piece of paper and hold them all up, including the people in the audience; but it would have been too embarrassing, because nobody would have had the same answers. This case is a published case from the Northern District of Illinois.

I have -- I could find hundreds of other cases. I found 427 district court cases that use the search term "hypothetical" in the question within Social Security. I can give you an unlimited supply of these. There is over 40 of them in circuit court cases.

The point is that the RFC, the hypothetical question presented by the ALJ. An ALJ sitting in one room with exactly the same set of facts with an ALJ sitting in another room, another hearing; exactly the same set of facts are going to

produce radically different RFCs. There is no reliability there.

When the question is presented to the vocational expert, you are dealing with a very, very idiosyncratic population of people. The vocational expert has no prior notice of the question. No prior notice of what direction the ALJ is going to go with the case. And he or she hears the question, and like I said, has to respond in about 15 seconds.

Not only do they give specific information about the jobs, let's say, sedentary security guard; but they will also say that there is 2,238. They will give very specific numbers. Where do the numbers come from? My experience in doing research for a number of years in writing books about it, and talking to a lot of vocational experts, and handling over 200 cases in district court, and handling hundreds and hundreds of cases at the Social Security Administration is that they make it up.

Now, we want to get away from the making it up part of things. But also where -- it's pretty clear that they haven't made it up; that they're

relying on some sort of vocational resource.

I know attorneys who have been working for a long time to use Rule 702 of the Civil Rules, Rules of Civil Procedure, and the standards of Dalbert as it's applied to civil litigation over a long period of time. We're using that to attack the validity and reliability of vocational information used by the Social Security Administration.

If -- I'm suggesting to you today that if you find that you are in a situation as an esteemed Panel -- I generally mean that. There is some really wonderful brain power here, wonderful experiences too. I am very grateful to see you working so hard, thinking so thoughtfully about this.

But if you find that you cannot answer -- provide a mechanism that allows a job -- an ALJ to really adjudicate these cases fairly, allows the Social Security Administration to adjudicate these cases fairly, please have the courage and the determination and fearlessness to say, we can't do it. You, Mr. and Mrs. Social Security

Administration, have asked us to do something that we cannot do.

The end user is not the Social Security Administration. The end user is the clients that Beth Alpert represents, and the other attorneys that you will be hearing from over a period of time. It's a person that I called yesterday to tell her we had lost her district court case, and had her sob, and sob, and sob, because she was going to lose her home. This stuff really matters.

There are other alternatives. If you can't make this work, don't despair. There is other things that you can do. Tommy Thompson in 1996, working with the Speaker of the House of Representatives, a republican, and a democratic president put together a Welfare-to-Work Program that's used in 50 states around the country, and also going to be used soon in Israel.

They take people who are disabled and disadvantaged, and rather than putting them through a long adjudication process, they put them through a process that determines whether or not they can

work, and they take the people that marginally can work, and they give them the tools that they need to work. Medical care, training.

When I was at Good Will I had people coming in who had never seen an alarm clock who were looking for jobs. I had people coming in from the Milwaukee population who did not know how to dial a telephone to make a call for a job appointment.

The Welfare-to-Work Programs around the country can take disabled and disadvantage people and train them to get jobs. And take them from being unemployed and unemployable to being tax payers again.

One of the things that I haven't heard mentioned -- and I didn't see any materials -- is cost effectiveness. The disability adjudication program that the Social Security Administration has is a very uncost-effective beast. Rather than spending those millions and millions of dollars to pay attorneys like me, and administrative law judges, and people who review reconsideration denials at the Social Security Administration --

state offices all around the country, take that money and put it into a Welfare-to-Work type program, where you take people who are disabled and disadvantaged and come to the Social Security in the first instance and say, I want help. I can't work. I'm losing my job.

Take those people, take them by the hand, and gently lead them back into world the work, using all the skills that all of you have. If you use it to just say "no," you are not doing the service to them, and you are not doing a service to yourselves, and you are not doing a service to the country.

DR. BARROS-BAILEY: Thank you, Mr. Traver. Ten minutes is up. I'm sorry to cut you off. I just want to see if anybody from the Panel has any questions.

Thank you. I appreciate your time.

MR. TRAVER: Thank you.

DR. BARROS-BAILEY: We have one more person presenting under the public comment, Marcie Goldbloom is our final commenter. Ms. Goldbloom is with Daley De Bofsky & Bryant. I hope I said that

correctly. Correct me if I didn't.

MS. GOLDBLOOM: Close.

DR. BARROS-BAILEY: Welcome.

MS. GOLDBLOOM: Thank you very much. I appreciate the opportunity to speak in front of this Panel. My name is Marcie Goldbloom. I am a partner at Daley De Bofsky & Bryant. I spend the great majority of my day representing the various kinds of claimants that Mr. Traver, Ms. Alpert, and Mr. Yates have been talking about.

Let me start by saying that in Disney World if we have all the money we can possibly have, Mr. Traver's suggestion might have more legs; but we actually have to deal with the worlds that we are in at the moment.

There is no question that a new system needs to be devised for various occupational vocational issues, because DOT, as we know, it's been antiquated. O*Net doesn't work. So it needs to be something new.

But we do need to assure that any new system affords each and every claimant a full and

fair adjudication to which they're entitled. Any system that Social Security utilizes has to have a degree of flexibility to recognize that these are individual people who all have different far ranging impairments.

And as Mr. Traver pointed out, we do very often have clients who end up being described as a 49 year old individual with 11th grade education, partially in special ed, who has back problems and depression, and she is obese, and she has carpal tunnel syndrome, so there is a variety of individual impairments with limitations that all have to be taken into consideration.

And my concern is that there is going to be a premium put on having a device in place that is neat and has boxes that everything can fit into, and the problem is that these people just don't really fit neatly into boxes; and that has to be kept in mind. Because as Mr. Traver explained, these are very real people, and when they lose claims, they lose their cars, they lose their houses.

I have people calling me everyday saying I

can't pay my rent. I'm about to get evicted. What do I do? Those are always really difficult phone calls. Most of them are in the process where we haven't actually had a decision yet; but too many of them are after a denial decision, and we have to decide whether to take that case to the District Court or the Court of Appeals. We to take a tremendous number of them. And that brings me to court, and that brings me to the Dalbert case.

Regardless of what kind of a model is utilized, Dalbert, from the Supreme Court, basically says that it's got to be reliable, and that's the bottom line. And it says that standards of reliability and relevance under the Federal Rules have to be met.

What they look at is the reasoning or methodology underlying the testimony or evidence scientifically valid, and whether or not that reasoning or methodology can properly be applied to the facts and issues. Also, they look at something. They say, can the methodology be tested? They want you to look at the potential rate of error. And if

you can't look at the methodology and say well, what's the rate of error going to be here; then, I think you have to go back and reevaluate and say, maybe this isn't going to be reliable enough.

I do have faith. I agree. I think there is some marvelous people involved here; and I hope that all of these concerns are taken into consideration, so that down the road we do have a methodology, a system that works both for Social Security's requirements, and to meet the needs of my clients. So I thank you very much.

DR. BARROS-BAILEY: Thank you for your time to come here. Are there any questions at all?

Okay. Thank you.

Thank you to the four public commenters for your time to come here to present to us. We really appreciate it. We are past due for a break. Lets' go ahead and take a break. It is 3:05. Let's come back at 3:20. Okay. Thank you.

(Whereupon, a recess was taken.)

DR. BARROS-BAILEY: Okay. We're going to go back on the record. At this point our final

session for the day will begin with the report of the Chair of Mental Cognitive Subcommittee, followed by Panel discussion and deliberation. I think we will have a little bit of time to come back to any additional comments or questions in terms of the deliberation for physical demands.

So at this point I would like to turn it over to David Schretlen.

DR. SCHRETLEN: Thank you, Mary.

Yes, we will have plenty of time. I notice on the schedule we have 3:30 to 5:00. I'm only going to talk for a few minutes.

Basically, since the last meeting -- or leading up to the last meeting, we reviewed published literature that has addressed the question of what are the underlying or latent dimensions of human cognitive functioning that might merit inclusion in a mental residual functional capacity assessment. That is a huge literature. And I presented some of those findings at the last quarterly meeting, and pointed out that, in fact, there are probably a variety of ways you can carve

up the pie of cognitive functioning, if you will. And to varying numbers of slices that are scientifically defensible, and will account for the bulk of variability and cognitive functioning. And we know that cognitive functioning is very important to work.

However, I thought that it was going to be more difficult to figure out the important dimensions of psychological and interpersonal and emotional functioning. Those are in many ways a bit softer than our neuro cognitive performance variables, which I think we can measure fairly reliably and fairly efficiently.

So in order to approach that, the mental cognitive subcommittee, after some discussion, decided to convene a roundtable, and the roundtable was -- the aim of the roundtable was to draw on the expertise of others outside of the mental cognitive committee who have spent time working with individuals who have various medical neurological and psychiatric disorders that interfere with work.

And these are experts who work with

patients clinically, or who have done research involving factors that are limiting factors in terms of the ability to work, or factors that enable people to get back to work with rehabilitation. So we tried to draw a fairly wide -- in a short period of time, a matter of a couple of weeks, Debra did the heavy lifting of contacting a number of people that were nominated by Bob Fraser and others on the Mental Cognitive Committee. We looked into the literature. We went on the internet and found centers; and in fact, although, we invited quite a few people, it took a while to get together a group of experts who could join us on such short order.

We had that meeting this Monday, and it was an all day meeting. And ultimately, in addition to the panel members of that subcommittee and other SSA staff, we -- included in the roundtable were Dr. Gary Bond from the University of Indiana, Purdue, who actually told us that he is going to be going to Dartmouth University; but he is a very, very accomplished rehabilitation psychologist who has been publishing for many years, scores of

articles on factors that influence the ability to work in individuals with psychiatric and neuropsychiatric disorders.

We also had Dr. Susan Bruyere from Cornell University where she is a director of a Disability Institute that conducts a great deal of research, provides some services, but primarily research. And Sally Rogers, also a psychologist. She is from Boston University, and has done an enormous amount of research in terms of situational kinds of assessments of work-relevant abilities.

In addition, we had Lynda Payne. Dr. Lynda Payne was a psychologist and a consultant examiner for DDS. She regularly evaluates medical records to determine -- to make determinations of mental residual functional capacity.

And finally, Dr. Pamela Warren, a vocationally-oriented psychologist in private practice, and also is associated with the University of Illinois.

So we really had a very broad representation on the roundtable. I think it was a

really very helpful group. And the question that we put to them were four fold.

First, we asked each of the guest whether they thought the existing mental residual functional capacity assessment tool is adequate or needs revision? And not surprisingly, there was uniform agreement that it does.

The second question we asked them was, for each person to think about -- ahead of time based on their clinical experience or research experience what are the -- to develop a list of about ten core dimensions or categories of emotional, interpersonal, psychological functioning that can be impaired by disease or illness; and if impaired, make it difficult for a person to work.

And we asked people to be -- to try and be as parsimonious as possible. So to come up with maybe ten or so. And to -- to try to cover the water front in terms of the abilities or dimensions of human functioning that they think are most relevant to a person's ability to work.

And then our third question was --

DR. GIBSON: Analysis.

DR. SCHRETLEN: Oh, yes. We asked people to let us know if they were aware of existing literature or databases of analyses of person of psychological or interpersonal function, and their relationship to work ability or disability.

And finally, we asked people to spend some time thinking about how -- how we ought to go about trying to measure these things. What would be the most useful way to measure? And whether that's rating, or direct observation, and so forth.

What came back was a very useful response from the roundtable participants. People did give us lists, and we will be compiling those lists and trying to look -- search for commonalities.

It was amazing how many times certain things came up. In almost everyone's list we found that people brought up issues related to many of the issues that are on the existing mental residual functional capacity questionnaire. That is, matters related to persistence, to concentration, to a person's ability to deal with other people, and to

cope with or respond effectively to supervision, and to deal effectively with co-workers, to comport themselves, to make -- to understand and follow directions, to express themselves, and to understand language.

So these were, you know, sort of facets of functioning, if you will, that were repeatedly mentioned by various Panel members. And our next step is to sort of go through and develop a matrix of abilities by panelists, and try and identify what are the overlapping areas, and what are the areas that might be important, but unique, and not captured by multiple people.

So that's what -- so Dr. Fraser and I will be working on that. And once we have done that, the next step is -- after circulating among the Mental Cognitive Subcommittee a provisional draft list of dimensions or categories of ability. What we would like to do is -- and this was Dr. Fraser's idea. I think it is an excellent idea -- is to do a survey of consulting examiners, like Dr. Payne, and some adjudicators, and some experts in the field.

Some of the roundtable participants, we will go back to them; but also some additional individuals who have expertise in those areas, and ask them what they think of those items. How the -- whether they think they are important to include. Whether they think that we are not including some essential elements. Whether they, you know, have suggestions about how to word the items. In other words, our goal is to make sure that people who will be using any instrument designed to assess residual mental and functional capacities have had a chance to give us some input along the way, so that we're going to be trying to balance what we know sort of from scientific evidence about what are predictors of work disability and return to work, and individuals with neurological and psychiatric disorders, with what are measurable, observable characteristics.

What people who are in the front lines who are adjudicators and consulting examiners recognize, based on their experience, as characteristics that they can -- that one can elicit reliable ratings of,

that we can measure in a reliable and valid way.

And once we have constructed that initial list, we will circulate it in a survey fashion to get feedback; and we will use that feedback to continue to refine the list. And in all likelihood, have some additional rounds of feedback, but it may be after the September deadline at that point. But we will be using that kind of feedback to nominate some candidate aspects of cognitive functioning to include into a mental residual functional capacity assessment.

In addition, and finally, at the roundtable we also went over the existing MRFC assessment document. And we asked panelist and guests to comment on the items. And it was remarkable how much consistency there was in terms of the difficulty with the items. So that we went through each item and identified what people who work with this questionnaire feel are the problems.

So on just -- for example, the very first item, the ability to remember locations and work-like procedures. You know, we heard several

people say, well, locations of what? Locations of where you work. Or where the tools are that you need to work with. And why are we asking about work-like procedures rather than just work procedures?

So people -- panelists had comments about all of the items on these, and not all of them were negative. I think that there were a number of items on here that people recognize could be very useful. We would not want to throw out. In fact, there are probably a number of items on here that we will either retain as is, or with minor modification.

So -- so let me see. The issues that came up again and again in terms of the limitations of the existing items, are that some items are compound. Does a person have an A or B? That's a problem, because a person may have a limitation in one area, but not another. So it's confusing for anyone who is going to be -- for adjudicators or anyone having to make a decision.

Another issue that came up repeatedly is that the questions are all cross sectional. How

does the person do this? But in fact, many diseases and conditions are relapsing and remitting conditions, and things change over time. And so there is widespread agreement that we need to better capture longitudinal aspects of limitations. That someone might not have a -- you know, an impairment of concentration all the time, but intermittently they have a terrible time with concentration.

If someone has relapsing and remitting bipolar disorder, they may have episodes of really severe depression and they can't get out of bed, or become quite grandiose and they are unable to relate to others. When they're between episodes, they are quite reasonable. So we need the instrument. I think people recognize the need to somehow capture longitudinal aspects of psychological functioning.

There is -- a third issue is inadequate quantification. Many of the wording -- many of the items have words like -- just, for example, the ability to understand or remember very short and simple instructions. Deep bursts and other items, or detailed instructions. It is just sometimes

difficult to know with adjectives like that, and a number of people said it would be helpful to have a little bit more precise quantification of limitations in these areas.

And then I think that as we talked about it, there seem to be very little in the way of an overarching, conceptual model. There is like a list of items, and the items are listed on the MRFC in a somewhat idiocratic fashion. So the first cluster is understanding and memory, which are cognitive abilities. Then we go down to sustained concentration and persistence.

Sustained concentration -- concentration is a cognitive ability, but persistence probably has more to do with in some ways energy initiative, capacity to get up and get out of bed and stay at work and so forth. And so we talked about the needs -- you know, we think that it would be helpful to have a more coherent conceptual organization of the items that are considered in the course of a mental residual functional capacity assessment.

I think that those were the major. And

then notably, some inconsistent coverage. Some items were covered -- some areas are covered in more detail than is probably necessary. They might have multiple items. For instance, it might be useful instead of having one dimension be the ability to follow simple instructions, and another one to follow detailed instructions, to have something like a single item that can this person, following simple instructions, moderately complex, or highly complex instructions? So that it's a single area, but rated more on a continuum.

Now, you know, we're not at the point where we're talking about how we are going to -- we're not developing the measures. We are just trying to identify the areas. In the process of doing that, I think it makes sense for us to consider what are the sort of most parsimonious and simplest and most direct ways to assess these, you know, a relatively small number of -- small and comprehensive number of dimensions or categories of functioning.

Anyway, those were the major things that

we have been working on in the mental cognitive subcommittee. And our plans for the next couple of months -- and I wonder, Bob, if you have anything to add or others on the committee have anything to add.

DR. FRASER: One or two points. I think you did a great job, Dave.

The one point you mentioned was kind of a longitudinal perspective. Because Dr. Payne pointed out that item eleven becomes the potpourri of perception item, because it has the parameter of over a work month, which no other item has. We probably should use that context for, in fact, all the items.

Just to underscore, you know, we want to be -- hit the most salient and comprehensive dimensions that we can; but also the emphasis on parsimony. Having been a VE myself for 20 years, as a council trainer, and granted the secondo of hypotheses that come at you, can you imagine if these are cognitive or interpersonal behavior, and have your 15 or 20 seconds to go through the thousands of job categories is very hard to do. It

has to be useful, as he pointed out, because, ultimately, our applicant's, you know, economic self-sufficiency is at stake. It has also got to be usable to the VE, and the other experts in the room.

DR. BARROS-BAILEY: Does anybody have questions? Okay. Well, thank you. That was great.

And it's my understanding that we had a second roundtable scheduled for July that we may not need.

DR. SCHRETLEN: Yes. Thank you. We had planned to have a second roundtable in part because we did this so rapidly we were really having trouble finding people who would be willing to come in and share their expertise with us. We thought well, if you won't come in June, would you come in July. We thought we would have a second roundtable.

But at this point what we have got back was really so helpful that I'm not sure -- I think we have discussed whether we need a second roundtable. At this point we're thinking it might be more useful to just do the survey, and get some feedback from DDS folks who are dealing with these

issues everyday, so that they can let us know whether the categories of functioning that we are thinking about are the categories that they think are important to assess.

You know, just very, very provisionally we have talked about sort of dividing the field, if you will, into three major categories. One is cognitive -- sort of a cognitive decision making information processing set. And then interpersonal, how the individual deals with other people. And then a third set related to self-management, behavioral self-management. How you can comport yourself, and things like hygiene, and so forth.

So that's how we're thinking of it at this point; but again, it's very -- it's very tentative. It could change completely.

DR. BARROS-BAILEY: Sylvia.

MS. KARMAN: Hi. I just wanted to ask -- or at least ask for clarification. I know when we spoke yesterday in our subcommittee meeting, David and Bob, we had thought about also including in the survey the experts who had met with us on Monday,

and possibly any of those people that we had identified to meet with us in July. And so I was just wanting to know did you guys still want to do that?

DR. SCHRETLEN: Yes. I thought I said that.

MS. KARMAN: I'm sorry.

DR. SCHRETLEN: No, no; that's okay. I meant to say it, that we're going to definitely talk to the people that participated, and also the people who we reached out to in the second roundtable and asked if they could do that.

MS. KARMAN: Okay. Great.

DR. FRASER: I was just thinking, based on counsel Traver's comments, we might also want to include a sample of VEs in this area too, because they have to respond to the criteria, as do the psychologists.

MS. KARMAN: Actually, we love that idea. I know that's one of the things we want to be able to do in our user needs analyses. Some of the user needs analyses that we have done up to date will

also shed some light on the mental cognitive issues that adjudicators think are primary.

But one of the issues that we face with surveying people external to the Agency is the OMB, the Office of Management and Budget Paperwork Reduction Act requirement to not place a burden on the public. And we have to get our surveys reviewed by them if we go over a certain number of people, like, I think it's nine.

DR. FRASER: Nine?

MS. KARMAN: Yes.

DR. SCHRETLEN: Can the survey have two parts?

MS. KARMAN: So I think we -- we will talk about how we can deal with that. I just want to mention that. We didn't get as far as that discussion yesterday, I don't think.

DR. BARROS-BAILEY: Nancy.

MS. SHOR: I just wanted to add one item as you are looking at the mental RFC form. Not only the categories, but I have heard frequently there is a lot of confusion about what the form is intending

on marked and moderate. So that might be something to add to your survey.

DR. SCHRETLEN: Yes, thank you very much, Nancy. That's a really important question. Just so you know and everybody knows, that was something that we discussed at some length that clearly there is widespread dissatisfaction with the current rating system of not significantly limited, moderately limited, markedly limited, no evidence of limitation, or not ratable. Particularly the first three, not significantly, moderately and markedly.

There are a number of ways that we can address this. One way we can address this is with behavioral anchors. So we have very concrete descriptors of what we think is indicated by varying levels of impairment in that dimension.

Another possibility is to do it sort of distributionally, below the average, you know, in an average range above, and sort of describe that across different items, so that they're on the same sort of scaling. But there are other approaches that we can take as well. So we have definitely

considered, and we will continue to consider.

In fact, it may be that the deliverable that we provide in September will just outline some of the possibilities; and in fact some of the items we might want to code in terms of frequency. Like the person has difficulty, you know, getting out of bed, you know, less than once a week, you know, more than once a week sort of thing.

In other words, we might even be able to put frequency in the responses to the item. So that's what rated by the clinician or the consulting examiner, or the, you know, family member is something more descriptive quantitatively than the existing boxes.

MS. KARMAN: Something else that occurred to me, David. We also talked yesterday about involving the taxonomy and classification subcommittee. So I have not spoken to either Shanan or Mark. I don't know whether you had. So I don't know, this might be a good time to mention to them what you had in mind.

DR. SCHRETLEN: Yes, in fact, Mark has

heard it, because he was there at the table; but Shanan hasn't. That is, obviously we're trying to build a bridge between the person and job demand. So it makes sense for you guys to have -- on the job taxonomy side to have input, say, look, this is something no way we can measure it. Or maybe there is a way to measure it. And there might be some aspects of human functioning that we think are important to rate, and there are sort of threshold items. It doesn't matter whether they are job demands or not. Every job demands that you get out of bed -- pretty much every job.

So it may be there are -- it's not really relevant whether it's part of the -- you know, in the job taxonomy, in the job demands assessment. But on the other hand, it would be really helpful to have on the job side to say these things are characteristics, that this would map on to the dimension of job complexity. This would map on to the dimension of job exposure to the public, and so forth.

MS. KARMAN: One of the things I'm

thinking of actually is that, David, when you were talking earlier about -- and Nancy brought up marked to moderate, I know we're not creating a form. Just so we can address that work to person link, it's very possible that Mark and Shanan will be able to help us out with some -- to some degree with a recommendation with regard to measurement issues that SSA might need to consider there. Because the way it's measured in the world of work needs to somehow translate into, well, what would the link then be with a person, you know? So that's where I was coming from, is what I was thinking about.

The other thing that I was thinking of was -- I don't know if -- I was not able to go to the Physical Subcommittee meeting yesterday, because I was on the other subcommittee. I'm thinking we need to talk about psychomotor; and if there is an overlap there between the two committees. I don't know if anybody has already talked about this or not, so I don't want to.

DR. BARROS-BAILEY: I talked to Deb about it earlier; but I don't think that two subcommittees

have talked about it.

MS. LECHNER: I think we just assumed that some of the psycho -- if you are referring to things like coordination, and the sensory pieces, I think that we were assuming that that would -- that we would have to deal with that. I would be happy to let you deal with it whatever way you want to.

DR. SCHRETLEN: Have at it.

MS. LECHNER: I tried, Mary.

DR. BARROS-BAILEY: Okay. Any other questions? Anything else, David? Bob?

DR. SCHRETLEN: No, just to -- something that occurred to me, maybe actually sort of rolling over to the next little phase here. That is, I'm not entirely sure where pain fits in. Is pain psychological or is pain physical? Is that sort of the enduring mind/body question? Is it the age-old question of civilization, 1,000 years.

MS. LECHNER: That's absolutely psychological.

DR. SCHRETLEN: I thought it was physical.

DR. WILSON: It's definitely not work

analysis.

DR. SCHRETLEN: It's not work. That's what we are talking about. I mean, there is no work that's -- you know, that requires pain, you know what I mean?

DR. ANDERSSON: Actually, you can ignore it for the purpose of describing jobs, because it's not a descriptor of a job that I know of.

DR. SCHRETLEN: Right.

DR. ANDERSSON: So we do not have to worry about it.

DR. SCHRETLEN: But we do have to worry about on the person side.

DR. ANDERSSON: That's different. That's not the Panel's problem. That's your problem.

MS. KARMAN: I would like some help with that. But actually, I mean, maybe what -- to the extent it's something that the Panel would want to consider, the effects of pain -- so in other words, if I'm in a lot of pain, I'm going to have trouble concentrating. We're considering it in that respect. He is shaking his head.

DR. ANDERSSON: I am, because I hope you are not, and because I think it is -- I mean, your question is very -- a very pertinent question, and there is a good understanding of this. To some degree, pain is a central nervous system issue; but to what degree -- acute pain is fairly simply to understand and identify; but when you get to the issue of chronic pain, and it's always a question to what degree is it a central nervous system problem, or to what degree is it some type of intercellular problem, which at this point you don't understand? You can argue back and forth about that. You are not going to get anywhere, unfortunately.

DR. BARROS-BAILEY: Tom.

MR. HARDY: Well, as a vocational counselor and as an attorney, I have to say that pain is a disabling factor that comes up at different parts of the evaluation process; and therefore, is an area we have to get. Along with the ignored areas, I would like to -- since we are moving into deliberation, I think -- I would like to hear us talk a little bit --

DR. BARROS-BAILEY: We're there.

MR. HARDY: I think I would like to hear us talk a little bit about sensorium and hazards. I'm not sure where they lie, and who is picking those up with the pain problem.

DR. ANDERSSON: Tom, I'm not sure I understand you. Because I don't think that pain enters into what I would call for physical and psychological environmental, description of a job.

DR. BARROS-BAILEY: Right. I think maybe what we're talking about is the difference between the diagnosis and the function. So inasmuch as we're dealing with function and how that function works on the person side and the work side, I think that's where we will need to maybe be concentrating a little bit. Deb.

MS. LECHNER: On the physical side of things when you are measuring physical function, if pain is present, it's going to affect the physical performance on the testing. So there will be -- for example, if there is lower extremity pain, there will be an antalgic gait. That will then affect

their ability to walk and climb stairs and do some other activities. And will affect how they end up scoring on the test, regardless of whether they report that pain as a two or an eight or a five.

The actual manifestation of the pain, when it's present, will affect the outcome of the testing. And I would assume the same thing in the mental cognitive area. If pain is truly interfering with concentration, it would show up on a test of concentration.

DR. BARROS-BAILEY: I think what I was saying is whether it's the affect -- functional affect is physical or cognitive or mental, there are other things that we're going to be looking at besides just pain that would also have those functional results; and those are what we're looking at is the function, not the diagnosis that leads to that function.

MS. KARMAN: Yes, I think that -- I mean, if I'm understanding Gunnar properly, I would say that it's true that the way in which Social Security Administration evaluates pain is a policy issue. So

what the Panel has to deal with is, you know, will we be able to obtain information on the world of work and make that link back to the person's function in a way that enables us to assess the extent to which X, Y, Z affects function?

It may be pain; it could be a lot of other things. The point, only for our purposes -- for Social Security's purpose -- at least the way I'm seeing it -- would be that that might help us to be able to think in terms of a more holistic assessment of the human being, rather than just this -- it is over here, it is somatic; it's RFC. Oh, it is over here, it's mental impairment; that's mental RFC. Not necessarily.

You can have a somatic impairment, and, you know, we would need to fill out -- I mean, to get out of the mind set of filling out a form, you would need to assess the person's function in both the mental cognitive and physical area. So I don't know if that's kind of getting at your point.

DR. ANDERSSON: Yes, I think it is. I think it's a question of us describing what the job

criteria or the job description is; and then you have to evaluate whether or not the person can, in fact, do that, in which case pain plays a big role.

DR. SCHRETLEN: I suppose one way of thinking about it is analogously. People with certain psychiatric disorders have hallucinations. We're not really concerned about -- we don't have to rate on the MRFC whether they have hallucinations, but whether they talk to unseen others at work, and something like that, where they appear to be disorganized in their thinking.

So if a person has pain, but despite the pain can excerpt force, and has some level of range of motion, and can concentrate, and so on, and so forth; then it's -- in a sense it's irrelevant that they have it, to the extent that they're not limited in those dimensions.

DR. BARROS-BAILEY: Okay. Thank you.

Tom, you had a question earlier in terms of hazard and sensory, if that was being addressed.

MR. HARDY: And where?

DR. BARROS-BAILEY: Okay. Deb, you want

to address that?

MS. LECHNER: We have a section that we're addressing sensory -- you know, the smelling, hearing, that tactile sensation. Then the hazard piece, I think, comes into play in an environment. So we're documenting the chemical -- the presence of chemical exposure or air quality, noise, vibration, and lighting; and that kind of stuff.

DR. BARROS-BAILEY: Dave, I think on Monday we were also talking about safety kinds of issues in terms of the mental cognitive. Do you remember that discussion? We mentioned it earlier.

DR. SCHRETLEN: No, I don't.

DR. BARROS-BAILEY: Go ahead.

DR. GIBSON: I would just add as part of the work taxonomy many of those factors often fall out naturally. If you go back and look at the dimensions we have, working hazardous situations, for example, is on the list. Working with moving equipment will also be on the list. Sometimes that's actually part of the work context, which shows up in that taxonomy as well.

DR. FRASER: Just in terms of the ratings, where we need help in terms of industrial psychology. The rates should look more like those used on performance evaluations. You know, minimally acceptable means of improving. You know, something along those lines versus what we have now, which does not really relate to job function very well. So that's where maybe we need your help.

DR. BARROS-BAILEY: If you are not using your mike, you might want to turn it off. I don't know if that's why we're getting feedback.

DR. SCHRETLEN: Right, some of the alternatives at some point.

And again, we are not making a forum here. That is not going to be a part of the deliverable; but we want to think about it, because it might impact the way we word things, and how we organize it.

We had talked about -- Bob and I had talked about the possibility of could some of the alternatives be framed in terms of work complexity? Since R.J. has shown us so clearly how important

work complexity is, it might be that decision making, understanding, structuring, and so on. Could it be framed in terms of, could a person do this in terms of low complexity work, average complexity work, or high complexity work in some way? Maybe it's -- you know, maybe it is more discrete than three.

Actually, I think there is a lot of evidence that having a relatively small number of categories, three or five, that actually tends to yield more reliable ratings than when you have ten alternatives. But that's another thing we wondered about, whether we could frame some of the dimensions rating in terms of -- I wonder if clinicians might be better able to -- can this person do this kind of thing at the level of low complexity work, for example; then list some low complexity kinds of jobs, or moderate, or average complexity, or high complexity. That might help anchor raters thinking. Help them -- anyway.

DR. BARROS-BAILEY: Before we went into the public comment, we were having quite a bit of

discussion as a result of the physical demands subcommittee; and I kind of cut that short so we could go into the public comment. I wanted to bring that back up again to see if we -- if people had additional questions.

I know that the kind of question on the table was the link of physical demands to task. Go ahead, David.

DR. SCHRETLEN: Yes, actually I did, because it occurred to me, Deb, that the list of -- in your outline -- shoot, I'm not seeing it. In your outline of physical -- categories of physical demands, manual materials, position, tolerance, mobility, movement, hand function, things like that; and you had some others on your lists.

Have you -- it occurred to me that -- I remembered Dr. Harvey's presentation of the factor analytic findings from the varying job taxonomies, and that some of the lower level factors in the sort of five, six, seven range had a lot of the words that were coming up on your slides. I'm wondering have you made an attempt to sort of map on to the

factor analytic findings of what you think of is the major demands of physical assessment or functional? Do you think that might be useful?

MS. LECHNER: Only in the sense that in looking at the PAQ and the CMQ, what I did in terms of the -- just comparison of the different systems is essentially a very similar exercise that I think Mark and Shanan went through for the broader taxonomys, just to list all of the physical demands that were categorized in the systems. And then, you know -- so that you could look across a single dimension and say well, you know, all three of them address stooping, and all three of them address handling. Is that what you were meaning?

DR. SCHRETLEN: It's just they had done a sort of more quantitive analysis of what are the -- what are the core characteristics that differentiate among occupations based on a broad array of job taxonomies. And I just was struck by how much overlap there was with some of the words that appear on the physical RFC assessments, pushing, pulling, you know, so on. And they appear on those. And I

wonder if they could provide some guidance.

Because one of the questions I heard you saying is it is not clear whether it makes sense to expand beyond this or not. Maybe one way of helping to decide that would be to look at what our colleagues have found here.

DR. ANDERSSON: I mean, you could describe this as -- if you go to the taxonomy that we talked about yesterday, we can go back and quote mega activities would be manual material handling, for example; and all these different things underneath would be, you know, occupational activities that are related to this mega activity. And I don't know how useful it is for the purposes of describing the jobs, and I have been sort of trying to figure out how to best incorporate some of these things that we have been talking about in our subcommittee.

I actually look at this as fairly simple. And the reason I look at it as simple is that all we're trying to do is describe the job. If we were trying to describe whether or not the job was harmful, I would be really open; but all we're

trying to do is describe the job. So what you do is you divide it into what kind of -- from a physical point of view, you are concerned about the posture of any part of the body and of the body itself. You are concerned about movements that you either do with your entire body or with parts of your body. And you are concerned about what you are doing with your movements; lifting, pushing, pulling, turning, twisting, whatever else it is.

And all you really have to do is list the ones. Then you can go out to any job, and you can basically describe the job in those functions. I am probably looking at it too simplistically, but --

DR. SCHRETLEN: No, I don't think you are. But I think that, you know, as we look over -- as Deb presented some of these systems, there -- like the RULA, and the OWAS -- I mean, these are incredibly detailed, complex system. I agree with you. I think it's going to be important to pare it down to the most parsimonious system.

DR. ANDERSSON: Right. And you have to remember that many of those ergonomic systems have

been developed as an economist doing the evaluation from the job. You have to somehow report the finding in some terms. You have to make sure that what you are reporting is truly representative of the job that you are analyzing.

Now, we're looking at much broader categories. And if I were to go into a specific workplace and look at the specific job, I would probably also use some of these devices to more specifically analyze the job. That might help me suggest changes that would make the job easier in many ways for the worker, or for putting a disabled person back to work. But if I'm just trying to describe the job, I probably wouldn't use any of those. I think they're just too complicated.

DR. BARROS-BAILEY: Mark.

DR. WILSON: I think it's important to keep in mind -- and I made this observation before, but I think it's difficult for people who actually practice in this area and do this work to think in the same way that people like me think about work; and this sort of factor analytic dimensional

approach to things, as opposed to the actual operational level which, you know, we would describe it as being done at the item level, or in the weeds or things of that nature.

That's not a bad thing, but if you look at the task that's before us, it's hard not to think in terms of those items; but in order to be successful we have to identify, I think, empirically valid taxonomies that force us to look at the entire water front. You know, we may at some point decide there are parts of the water front we're not that interested in. So what I thought David was asking about -- I wanted to clarify this -- we were talking about the -- sort of the crosswalk to what Debra was saying earlier to the sort of empirical analysis of the DOT data. I thought there was kind of a striking similarity here.

You know, after you get past data people things, which, you know, no surprise that those of us in the area emerge very quickly, all the next ones, gross, postural, reaching, handling, color, sensory, gross body movement, visual --

DR. SCHRETLEN: Exactly.

DR. WILSON: Unpleasant for Tom, who's nodding off over there. Unpleasant hazards, and then precision work. What we were doing in our committee -- and I see this is useful for -- and I also felt the same way about a couple of Debra's slides -- is that helps us not so much to provide guidance; although, I think it's important to maybe -- and we did that in one of our fact findings earlier in one table for illustrative purposes. You know, it's hard for sometimes people to really get what we're talking about when you're doing all this factor analysis and things of that sort. What's important is to give examples.

But the reason that the taxonomic work is important, the reason that these factor analyses and reviews of the literature are important is so that you don't need some major area of physical or cognitive or interpersonal activity unexplored at least from a due diligence standpoint. It could be at some point Social Security says, that's nice, Mark, but we're not interested in that. You know,

we don't want to go there. Maybe somebody else does. But I feel it's important for us to at least make them aware of what the empirical literature says of what's been found.

And I think the other thing here that we have to remember is, you know, once you get past the position, you know, the specific activities that one individual does in the workplace, all of this stuff is a distraction. One person's organization of how they describe jobs can be very different from the same activities in another organization, very different job titles, very different groupings. So you can almost think of these other levels of analyses, whether we talk about these as tasks, or meta tasks, or generalized work activities, or factor scores, or OUs or level one or five; yeah, they're different levels of precision, but there is almost an infinite level of strengths on that microscope that you can make.

And I think the task for us is really -- I'm going to say it again -- daunting in the sense that we have to hit exactly the right level of

specificity here. We can't overwhelm the system. We can't demand too much of these people who are under a lot of production pressure in terms of the amount of detail. But at the same time if we don't make it detailed enough, then, it doesn't allow them to make the important distinctions that we heard over and over again are important, and needs to be there.

So any way that I can help in terms of clarifying the work side analysis of what it is we're talking about, what the differences between task analysis and generalized work analysis and things of that sort, I would be happy to do.

DR. ANDERSSON: I think at the same time it becomes important to classify jobs such that you can analyze a disabled person when you are telling them whether or not they can do the job. So you have to have some kind of reasonable level.

Today, for example, in the musculoskeletal area, it is fairly common to do a functional capacity evaluation. Same too, a certain number of things that you ask the person to do and determine

whether or not they can do it. If you become too detailed, it just falls apart. If you require those to go on for days and weeks, it just isn't possible. So if you have some connection to what you can objectively determine about the individual too.

MS. LECHNER: I would agree with that. The other thing that makes it a bit of a challenge -- you know, just take the manual materials handling activities as an example. If we did some sort of factor analysis, we could probably take out one representative manual materials handling task that would be fairly -- you know, if they score this way on this, most people are going to score similarly on the rest of the items in that battery of tests. So you could probably identify that factor analysis.

Some of the challenges on the person side when they come in to be tested -- you know, for example, if we decide our representative task for that manual materials handling section to be a floor to waist lift, and that really predicts most of the other performance, and most of the other test items;

then somebody walks in with a shoulder problem, they can do a good floor to waist lift. It's not until you ask them to lift above waist that you begin to see their deficit.

So if a job requires -- or the occupation requires a lot of above waist lifting, then, you are going to miss that whole mix match between the person and the job. So it kind of speaks to that whole issue of you have got to -- we could probably cluster a lot of these things and develop a screen that would take 30 minutes instead of four hours. But we may have to do that by diagnosis or by body part if we want to get anything that's really meaningful to that individual claimant.

DR. WILSON: Or even maybe to sort of extend that idea, perhaps there is some sort of hierarchical range we can identify that, you know, rules in, rules out various kinds of measures. So that -- and we keep Gunnar happy.

The individual analysis might be relatively simple, but the number of possibilities could be more detailed compared -- you know.

Because we have heard time and time again all these cases are different. There are complicated and varied sets of psychological and physical symptoms that may present themselves.

So in terms of the work side, our -- at least initially approach, can -- and Shanan can chime in here, you know, if she feels it's necessary -- is that we wanted to cast a broad as net as possible. We wanted to give SSA as many different work descriptor dimensions from which however many items can be generated, so that they can make that decision. We didn't want to, based on what limited -- you know, I mean, there is so -- yes, there is research in a lot of these areas; but there is not -- at least not on our side; and I suspect not on the person side either -- true national databases that has looked at all work. I mean, that just doesn't exist.

So there are little snippets and pieces here and there, and different researchers of different levels of competence who have looked at these various issues; and that's all we have to work

with.

And so my approach has been -- all along is that I think this is going to be a sequential process of the -- with, you know, perhaps, one or more research steps where we pilot, and you know, develop prototypes, and take them out to VEs, and give them a few options. And as much as possible within Social Security Administration develop this sort of research and development, and ultimately, a maintenance and update function that's part of the Agency. I don't think this is -- they are the only ones that I think can consistently and on an ongoing basis maintain this kind of -- it is my personal opinion, but --

DR. ANDERSSON: I think you can fit a number of these under your heading. For example, if you look at what you describe as activities related to building, repairing structures. So that doesn't tell me a lot. If I want to know what the physical demands of that job is, I have to know what this person is actually doing.

Is he just sitting there drawing a

building? Or is he, in fact, out there carrying and doing a lot of very physical activity? So I have to have some kind of physical descriptors underneath your heading on activities related to building and repairing structures.

And when I look at your crosswalk, what you are trying to do, I think, is describe what typically would fall under these different categories; and I don't have a problem with that. I think what we're trying to do is to be much more detailed under one or two of these specific categories.

DR. WILSON: Right. And if I didn't make it clear, I apologize; but these are just categories for the very kinds of things you are talking about. They're meant to stimulate those kinds of questions. We want to go to people like you and say, what do you want to know about activities related? What would be helpful to you to make the decision that you have to make?

DR. GIBSON: I was going to say I was going to regret -- apparently, I'm not -- that we

have actually come back there in the past couple moments. I was going to build on that. I'm actually going to concede something to Mark. So don't hold it against me. I will do it once this whole week, I think.

Going back to our discussion yesterday when we were having the -- joking around about the activities related to lifting, activities related to pushing; and by assistance if they stay; assistance if they leave, et cetera. Looking now at what Deborah has given us actually creates a very nice situation where he could probably argue that what it should have said was activities related to manual materials handling. Then a sample item would have been, lifting items under 25 pounds and how frequently would it occur.

I think that also gets to Deborah's question that day about is this really the level of detail? Again, that iterates these are categories that we created where we filled out much more highly specific questions. So activities related to manual materials handling, followed by items like lifting,

carrying, pushing, pulling in various levels.

Once again, having to have some sort of adaptive system, which no we can't ask, do you ever have to do manual materials handling? That would kill things. Do you ever have to lift things as part of your job? If the answer is "yes," there are follow-up questions that deal with the repetition issue, the height issue, or things of that nature.

DR. BARROS-BAILEY: Okay. Any other questions? Any other comments regarding physical demands?

Okay. Anything else regarding the mental cognitive user needs?

Is everybody ready to shut down for the day, sounds like? Okay.

Well, we're not at 5:00 o'clock yet, but tomorrow we will have the opportunity to deliberate on those other subcommittees. It sounds like we are at a point today where we can close our session.

So do I hear a motion to adjourn?

DR. GIBSON: So moved.

DR. BARROS-BAILEY: Moved by Shanan.

Do I have a second?

MS. KARMAN: Second.

DR. BARROS-BAILEY: And Sylvia second.

We are adjourned for today. Tomorrow morning at 8:30 here. Everybody have a good evening. Thank you.

(Whereupon, at 4:29 p.m., the meeting was adjourned.)

CERTIFICATE OF REPORTER

I, Stella R. Christian, A Certified Shorthand Reporter, do hereby certify that I was authorized to and did report in stenotype notes the foregoing proceedings, and that thereafter my stenotype notes were reduced to typewriting under my supervision.

I further certify that the transcript of proceedings contains a true and correct transcript of my stenotype notes taken therein to the best of my ability and knowledge.

SIGNED this 29th day of June, 2009.

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STELLA R. CHRISTIAN